**UNITED STATES BANKRUPTCY COURT**
**WESTERN DISTRICT OF WISCONSIN**

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**In Re:**

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| **GREDE FOUNDRIES, INC., et al.**[1] | **Case No. 09-14337 (Jointly administered)** |
| **Debtors** | **Chapter 11** |
| | **Hon. Robert D. Martin** |

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**DEBTORS' MOTION FOR AN ORDER AUTHORIZING DEBTORS TO TERMINATE HEALTH PLAN BENEFITS FOR NON-UNION RETIREES**

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Grede Foundries, Inc., et al., debtors and debtors-in-possession (the "Debtors"), hereby submit this Motion (the "Motion") for the entry of an Order authorizing the Debtors to terminate coverage of Non-Union Retirees ("Non-Union Retirees") under the Grede Foundries Group Heath Plan (the "Group Health Plan"), Medicare Supplement Plan (the "Supplement Plan"), Group Life Insurance Plan ("Group Life Plan"), and Aetna Medicare D Plan (the "D Plan")(collectively, the Group Health Plan, Supplement Plan, Group Life Plan, and Plan D will be hereafter referred to as the "Plans"), effective February 28, 2010. In support of this Motion, the Debtors respectfully state as follows:

**Background**

1. The Group Health Plan covers two categories of retirees: (1) the Non-Union Retirees (there are three Non-Union Retirees and 1 spouse covered by the Group Health Plan); and (2) those retirees who were union members (this group has approximately 230 retirees and

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[1] The Debtors in this jointly administered proceeding are Grede Foundries, Inc., Grede Transport, Inc., and Grede-Pryor, Inc.

145 spouses or dependents). This motion only addresses the Non-Union Retirees.[2] The Debtors spend approximately $1,624.00 per month providing Non-Union Retirees with coverage under the Group Health Plan.

2. The Debtors spend approximately $28,595.23 per month providing coverage under the Supplement Plan for approximately 313 Non-Union Retirees.

3. The Debtors spend approximately $10,493.00 per month providing coverage under the Group Life Plan for approximately 664 Non-Union Retirees.

4. The Debtors pay no portion of the D Plan, a coverage that approximately 171 Non-Union Retirees elected and for which they personally pay.

5. The Non-Union Retirees are not covered by the collective bargaining agreement between the Debtors and Local 564 of the United Steel Workers, and as such any benefits the collective bargaining agreement affords union retirees do not extend to the Non-Union Retirees.

6. Any claims for services or supplies covered by the Plans that have been incurred by the Non-Union Retirees on or before February 28, 2010 are the responsibility of the Debtors, and the Debtors have the ability to and will and have honored these obligations.

**Relief Requested**

7. The Debtors hereby request entry of an Order authorizing the Debtors to terminate the coverage of the Non-Union Retirees under the Plans, effective February 28, 2010.

**Basis for Relief**

8. Section 105(a) of the Bankruptcy Code provides a bankruptcy court with broad powers in the administration of a case under the Bankruptcy Code. Section 105(a) provides that "[t]he court may issue any order, process, or judgment that is necessary or appropriate to carry

[2] In accordance with §§ 1113 and 1114 of the Bankruptcy Code, the Debtors intend to file a separate motion addressing the termination of Group Health Plan coverage for the union retirees.

out the provisions of [the Bankruptcy Code]." 11 U.S.C. § 105(a). Provided that a bankruptcy court does not employ its equitable powers to achieve a result not contemplated by the Bankruptcy Code, the exercise of its § 105(a) power is proper.

9. The Debtors have the unambiguous contractual right to terminate health plan benefits for Non-Union Retirees at any time. The Group Health Plan as documented in the Anthem Health Benefit Booklet, states that "Grede reserves the right to terminate, suspend, withdraw, amend or modify the plan in whole or in part at any time. This right applies to retiree coverages and benefits . . . as well as to all other portions of the plan."[3] (Anthem Health Benefits Booklet, at 1, attached as Ex. A.) The Debtors' communications to their retirees have been consistent with the Plans. The employee communication materials, including the Anthem Health Benefits Booklet, and other plan documentation prepared by the Debtors and distributed to the employees from time to time clearly state that the Debtors reserve the right to amend, modify or terminate any provisions of the Plans, including those provisions that provide retiree benefits.

10. Employers are "generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995). This means if ERISA benefits vest at all, they do so pursuant to the terms of a particular contract. *See* Pabst Brewing Co. v. Corrao, 161 F.3d 434, 439 (7th Cir 1998).

11. There is a presumption against the vesting of welfare benefits, and as such "silence indicates that welfare benefits are not vested." Vallone v. CNA Fin. Corp, 375 F.3d 623, 632 (7th Cir 2004). Here, the Plans do not vest the retirees with any benefits, providing instead that retiree benefits are terminable at any time. Thus, it is clear that the retiree benefits

[3] Similarly, the Group Life Plan also allows Grede to "terminate, suspend, withdraw, amend, or modify the plan in whole or in part at any time." (Group Life Insurance Plan, at 1, attached as Ex. B.)

are not vested and that, consistent with ERISA, the health plan benefits for Non-Union Retirees are terminable.

12. The Plans are governed by both ERISA and the Bankruptcy Code. Section 1114 of the Bankruptcy Code generally governs payment of insurance benefits to retired employees. Section 1114 defines "retiree benefits" as:

> payments to any entity or person for the purpose of providing or reimbursing payments for retired employees and their spouses and dependents, for medical, surgical, or hospital care benefits, or benefits in the event of sickness, accident, disability, or death under any plan . . . maintained or established in whole or in part by the debtor prior to filing a petition commencing a case under this title**.**

11 U.S.C. § 1114(a).

13. Section 1114(e)(1) provides, in pertinent part, that the debtor "shall timely pay and shall not modify any retiree benefits," unless the court orders modifications of payments pursuant to §§ 1114(g) and (h) or if the debtor and representative of the retirees agree to such modification. *See* 11 U.S.C. § 1114. However, § 1114 is silent with respect to "whether the debtor can exercise a power reserved in the contract to terminate [a retiree benefits plan] and thereby end, without court approval, any obligation for retiree benefits as defined in § 1114(a)." In re N. Am. Royalties, Inc., 276 B.R. 860, 866 (Bankr. E.D. Tenn. 2002).

14. The majority of courts and the text writers agree that a debtor with a contractual right to terminate a retiree benefits plan can terminate the plan without seeking approval from the court under § 1114(g). *See* In re Delphi Corp., No. 05-44481, 2009 Bankr. LEXIS 576, at *6 (Bankr. S.D.N.Y. Mar. 10, 2009); 7 Collier on Bankruptcy ¶ 1114.03[1] (Alan N. Resnick & Henry J. Sommer eds., 16th ed. 2009).

15. Courts reason that there is no indication in § 1114 that Congress intended § 1114 to apply to claims for which the debtor has no contractual or legal liability. *See* N. Am. Royalties, 276 B.R. at 866-67 (finding that unilateral termination of the contract by the debtor, if

allowed by the terms of the contract, does not require the debtor to follow the procedures of § 1114); CF & I Steel Corp. v. Conners (In re CF & I Fabricators of Utah, Inc.), 163 B.R. 858, 874 (Bankr. D. Utah 1994) (holding that "[t]he Bankruptcy Code does not create new rights upon filing bankruptcy that were not in existence prior to filing."); In re Lykes Bros. S.S. Co., 233 B.R. 497, 517 (Bankr. M.D. Fla. 1997) (observing that retiree benefits that were terminable pursuant to non-bankruptcy law can be terminated during a Chapter 11 case without the need to comply with § 1114); and In re Doskocil Cos., 130 B.R. 870, 876 (Bankr. D. Kan. 1991), the seminal case on this issue, which states that § 1114 was not intended to create for the debtor new obligations not imposed by the terms of the retiree benefit plan.

16. Courts also point to the absence of any relevant legislative history, observing that if Congress intended to institute such a major change in retirees' contract rights, there most certainly would have been some discussion in the legislative history. Delphi, 2009 Bankr. LEXIS 576, at *10 (the scant legislative history makes it unlikely Congress intended § 1114 to create a major change in pre-Code practice, prohibiting companies from terminating retirement plans they have the contractual right to terminate); Doskocil, 130 B.R. at 876 (if Congress intended to use § 1114 to apply on claims for which the debtor has no contractual liability, it would have used language that made that intention clear).

17. When confronted with a motion requesting permission to terminate a retiree benefits plan from a debtor which has the contractual right to terminate, courts generally have given consent to plan termination without requiring compliance with § 1114(g) and the formation of a committee of retired employees. *See* In re N. Am. Royalties, Inc., at 866 (finding that a debtor could terminate retiree health benefits without following the requirements of § 1114, and that it was unnecessary to appoint a committee of retired employees); Doskocil, 130 B.R. at 876-877 (holding that retiree benefits could be terminated without compliance with

§ 1114, and that the formation of a committee of retired employees was an unnecessary expense when retirees have no right to continued coverage).

18. The Debtors are aware that there are two reported decisions standing for the proposition that a debtor cannot modify or terminate retiree benefits even if the debtor has the contractual right to do so. *See* In re Farmland Indus., Inc., 294 B.R. 903, 919 (Bankr. W.D. Mo. 2003) (holding that Congress did not intend to allow a debtor to modify retiree benefits under any circumstances without meeting the requirements of § 1114(g)); and Ames Dep't Stores, Inc. v. Employees' Comm. of Ames Dep't Stores, Inc. (In re Ames Dep't Stores, Inc.), No. 92 Civ. 6145 & 6146, 1992 U.S. Dist. LEXIS 18275, at *4 (S.D.N.Y. Nov. 30, 1992), *vacated on other grounds*, 76 F.3d 66, 69 (2d Cir. 1996) (which found that a debtor must comply with § 1114 before terminating benefits, even if the debtor has a contractual right to terminate). Notably, the Ames decision was roundly criticized by the Second Circuit Court of Appeals in In re Ames Department Stores, Inc. 76 F.3d 66 (2d Cir. 1996), where the Court of Appeals, without reaching this issue, criticized the district court opinion for not considering the substantial weight of authorities that allow a company that has a contractual right to terminate a retiree benefits plan to do so in bankruptcy.

19. The Debtors respectfully urge this Court to adopt the majority position and to authorize the debtors to terminate the Plans. The Farmland decision, which relies on the phrase "[n]otwithstanding any other provision of this title, the debtor in possession . . . shall timely pay and shall not modify any retiree benefits," is simply not good law. 11 U.S.C. §1114(e)(1). At bottom, Farmland is fatally flawed because it fails to acknowledge the interplay between § 1114 and § 1129, clearly the section of the Bankruptcy Code governing the confirmation of a plan. Section 1129(a)(13) "limit[s] the application of section 1114 to retiree benefits which the debtor has 'obligated itself' to pay, presumably pursuant to a prior contractual agreement." Retired W.

Union Employees Ass'n v. New Valley Corp. (In re New Valley Corp.), No. 92-4884, 1993 U.S. Dist. LEXIS 21420, at *11-12 (D.N.J. Jan. 28, 1993). As the Court in Delphi explained, §§ 1129(a)(13) and 1114 can only be harmonized, "by taking the view that each recognizes that the debtor's obligations under retiree benefit plans that are modifiable at will are qualified by a right under non-bankruptcy law to modify or terminate." Delphi, 2009 Bankr. LEXIS 576, at *15.

20. Thus, in light of the weight of authority supporting the Debtors' ability to terminate Plan coverage without Court approval under 11 U.S.C. § 1114, the Debtors hereby request entry of an Order authorizing the Debtors to terminate the coverage of the Non-Union Retirees under the Plans, effective February 28, 2010.

**Notice**

21. The Debtors will serve this Motion and a separate Notice of Motion on all parties on the General Service List as maintained pursuant the Court's Case Management Order entered in the Grede Foundries, Inc. proceeding. Additionally, the Debtors will serve notice of this Motion on the Non-Union Retirees who have coverage under the Plans. In light of the nature of the relief requested herein, the Debtors submit that no other or further notice is necessary.

**No Prior Request**

22. No prior request for the relief sought in this Motion has been made to this or any other Court.

WHEREFORE, the Debtors respectfully request that this Court: (i) enter an order granting the relief sought herein; and (ii) grant such other and further relief to the Debtors as the Court may deem proper.

Dated the 4th day of February, 2010.

GREDE FOUNDRIES, INC.,
Debtor and Debtor-in-Possession, by its counsel,
Whyte Hirschboeck Dudek S.C.

By: /s/ Alfredo M. Cantoral
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**EXHIBIT A**

**EXHIBIT A**

Anthem

# Health Benefit Booklet

## Blue Preferred Plus POS (for residents of Southeast Wisconsin)
## Blue Access℠ PPO (for all others)

### Important Notice Regarding Payment of Covered Services

Your Plan limits benefits for Covered Services to the Maximum Allowable Amount, as defined in the "Definitions" section at the back of this Benefit Booklet. The Maximum Allowable Amount may be less than the amount billed by your Provider. Please see page 89 in the "General Provisions" section for information on how to determine what the Plan will cover as the Maximum Allowable Amount.

**Administered by**
Blue Cross Blue Shield of Wisconsin dba Anthem Blue Cross and Blue Shield

**To Contact Us Please Write / Call:**
P.O. Box 34210 OH23A-700
Louisville KY 40232-4210 1-800-490-6201

**Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.**

**Grede reserves the right to terminate, suspend, withdraw, amend or modify the plan in whole or in part at any time. This right applies to retiree coverages and benefits (for both benefits before and after retirement) as well as to all other portions of the plan.**



Effective Date: January 1, 2007
Grede Foundries, Inc. ASO -
BCBSWI/CCB/FP-06 (7/06)

# INTRODUCTION

This Benefit Booklet has been prepared by Us, on behalf of the Employer, to help explain your health benefits. Please read this Benefit Booklet carefully, and refer to it whenever you require medical services.

This Benefit Booklet describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Many of the provisions in this Benefit Booklet are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. You are responsible for knowing the terms of this Benefit Booklet.

This Health Benefit Booklet overrides and replaces any Benefit Booklet previously issued to you. The coverage described in this Benefit Booklet is based upon the conditions of the Administrative Services Agreement issued to your Employer, and is based upon the benefit plan that your Employer chose for you. The Administrative Services Agreement, this Benefit Booklet and any endorsements, amendments or riders attached, form the terms under which Covered Services are available.

Many words used in the Benefit Booklet have special meanings. These words are capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these definitions for the best understanding of what is being stated.

If you have any questions about this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card or visit www.anthem.com.

# MEMBER RIGHTS AND RESPONSIBILITIES

## As a Member, You Have the Right to:

- Receive information about the organization and its services, practitioners, and providers, and member rights and responsibilities;
- Be treated respectfully, with consideration and dignity;
- Receive all the benefits to which you are entitled under the Plan;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under the Plan;
- Participate with your Provider in decision making about your healthcare treatment;
- Refuse treatment and be informed by your Provider of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express concern and complaints about the care and services your received from Providers, or the service you received from Us, and to have Us investigate and take appropriate action;
- File a complaint with Us, to appeal a decision, as outlined in the "Appeal Process" section, without fear of reprisal;
- Privacy and confidential handling of your information;
- Make recommendations regarding Our rights and responsibilities policies;
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

## As a Member, You Have the Responsibility to:

- Understand your health issues and be wise consumers of health care services;
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship;
- Provide complete and honest information we need to administer benefits and that Providers need to care for you;
- Follow the plan and instructions for care that you and your Provider have developed and agreed upon;
- Understand how to access care in routine, Emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Coinsurance, Copayments, etc.;
- Notify your Provider or Us about concerns you have regarding the services or medical care you receive;
- Keep appointments for care and give reasonable notice of cancellations;
- Be considerate of other Members, Providers and Our staff;

- Read and understand your Benefit Booklet and Schedule of Benefits, and other materials from Us or your Employer concerning your health benefits;
- Provide accurate and complete information to Us about other health care coverage and/or insurance benefits you may carry; and
- Inform your Employer of changes to your name, address, phone number, or if you want to add or remove Dependents.

# TABLE OF CONTENTS

# SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums, and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms, and provisions of this Benefit Booklet including any endorsements, amendments, or riders.

**This Schedule of Benefits lists the Member's responsibility for Covered Services.**

**To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider.** Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use a Non-Network Provider you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges.

**Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.**

**BENEFIT PERIOD** Calendar Year

**DEPENDENT AGE LIMIT** To the end of the calendar year in which the child attains age 25, if the child qualifies as a federal tax exemption.

**DEDUCTIBLE**

| | Network | Non-Network |
|---|---|---|
| Per Member | **Low Option:** $250<br>**Medium Option:** $500<br>**High Option:** $750 | **Low Option:** $500<br>**Medium Option:** $1,000<br>**High Option:** $1,500 |
| Per Family | **Low Option:** $500<br>**Medium Option:** $1,000<br>**High Option:** $1,500 | **Low Option:** $1,000<br>**Medium Option:** $2,000<br>**High Option:** $3,000 |

Note: The Family Deductible is an aggregate Deductible. This means any combination of amounts paid by family Members toward Covered Services can be used to satisfy the Family Deductible.

Note: The Network and Non-Network Deductibles are separate and cannot be combined.

NOTE: The Deductible applies to all Covered Services with a Coinsurance amount you incur in a Benefit Period except for the following:

- Emergency Room services when subject to a Copayment plus Coinsurance
- Prescription Drug benefits

Copayments are not subject to and do not apply to the Deductible.

**OUT-OF-POCKET LIMIT**

| | Network | Non-Network |
|---|---|---|
| Per Member | **Low Option:** $1,500<br>**Medium Option:** $2,500<br>**High Option:** $3,750 | **Low Option:** $3,000<br>**Medium Option:** $5,000<br>**High Option:** $7,500 |
| Per Family | **Low Option:** $3,000<br>**Medium Option:** $5,000<br>**High Option:** $7,500 | **Low Option:** $6,000<br>**Medium Option:** $10,000<br>**High Option:** $15,000 |

NOTE: The Out-of-Pocket Limit includes all Deductibles and Coinsurance amounts you incur in a Benefit Period except for the following services:

- Prescription Drug benefits
- Non-Network Human Organ and Tissue Transplant services

Copayments do not apply to the Out-of-Pocket Limit.

Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period, except for the services listed above.

Network and Non-Network Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits are separate and do not accumulate toward each other.

**LIFETIME MAXIMUMS**

| | Network | Non-Network |
|---|---|---|
| **Lifetime Maximum for all Covered Services** | $1,500,000 | Network and Non-Network Combined |

NOTE: While Prescription Drugs do not accumulate toward the Lifetime Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.

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|---|---|
| **Morbid Obesity Surgical Treatment Maximum** | $20,000 Network and Non-Network combined |

Note: This maximum is limited to the Inpatient facility, surgical, and anesthesiology charges. All other charges for Covered Services related to morbid obesity surgery do not apply to this maximum.

| **COVERED SERVICES** | **COPAYMENTS/COINSURANCE/MAXIMUMS** | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Ambulance Services** | 15% Coinsurance | Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowable Amount. |
| **Behavioral Health & Substance Abuse Services** | Copayments / Coinsurance based on setting where Covered Services are received. | Copayments / Coinsurance based on setting where Covered Services are received |
| • **Inpatient Services** | Covered Services are limited to 30 days per Member per Benefit Period (Network and Non-Network combined). | |
| • **Transitional Care Services** | Covered Services are limited to 15 visits per Member per Benefit Period (Network and Non-Network combined). | |
| • **Outpatient Services** | Covered Services are limited to 30 visits per Member per Benefit Period (Network and Non-Network combined). | |
| **Childhood Immunizations** | Please refer to the "Preventive Care" provision in this Schedule. | |
| **Chiropractor Services** | Chiropractor Services are paid as any other Physician service. Please refer to "Physician Home Visits and Office Services" for details. The PCP Copayment will apply. | Chiropractor Services are paid as any other Physician service. Please refer to "Physician Home Visits and Office Services" for details. |

| | Network | Non-Network |
|---|---|---|
| NOTE: Please refer to the "Therapy Services" provision in this Schedule for details on the limit that applies to Manipulation Therapy.<br>NOTE: If therapy services are provided, those services will be subject to the limits listed under "Therapy Services." | | |
| **Dental Services**<br>(Does not include routine dental care.) | Copayments / Coinsurance based on setting where Covered Services are received. | Copayments / Coinsurance based on setting where Covered Services are received. |
| **Diabetic Equipment, Education, and Supplies** | For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule.<br>For information on diabetic education services, please refer to the "Physician Home Visits and Office Services" provision in this Schedule.<br>For information on Prescription Drug coverage, please refer to the "Prescription Drugs" provision in this Schedule. | |
| **Diagnostic Services** | When rendered as Physician Home Visits and Office Services or Outpatient Services, the Copayment / Coinsurance is based on the setting where Covered Services are received except as listed below.<br>Other Diagnostic Services and or tests, including services received at an independent Network lab, may not require a Copayment / Coinsurance.<br>Laboratory services provided by a facility participating in the Laboratory Network (as shown in the Provider directory) may not require a Coinsurance / Copayment. If laboratory services are provided by an Outpatient Hospital laboratory that is not part of the Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit. | |
| Note: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services are subject to the Other Outpatient Services Copayment / Coinsurance regardless of setting where Covered Services are received. | | |

| | Network | Non-Network |
|---|---|---|
| **Emergency Room Services**<br><br>Copayment / Coinsurance is waived if you are admitted | $100 Copayment plus an additional 15% Coinsurance | Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowable Amount. |
| **Home Care Services** | 15% Coinsurance | 35% Coinsurance |
| Maximum Visits per Benefit Period | 40 visits, Network and Non-Network combined | |
| NOTE: Maximum does not apply to Home Infusion Therapy, Manipulation Therapy or Private Duty Nursing rendered in the home. | | |
| Private Duty Nursing | | |
| Maximum per Member per Benefit Period | $50,000 | |
| Lifetime Maximum | $100,000 | |
| **Hospice Services** | 15% Coinsurance | 15% Coinsurance |
| **Inpatient and Outpatient Professional Services** | 15% Coinsurance | 35% Coinsurance |
| **Inpatient Facility Services** | 15% Coinsurance | 35% Coinsurance |
| **Kidney Disease Treatment** | Kidney disease benefits include dialysis, transplantation, donor-related costs, and transplant-related services.<br>Transplants are covered under the "Human Organ & Tissue Transplant" provision in this Schedule.<br>Non-transplant benefits are subject to Copayments / Coinsurance based on setting where Covered Services are received. | |
| **Lead Poisoning Screening** | Please see the "Preventive Care" provision in this Schedule. | |

| | Network | Non-Network |
|---|---|---|
| **Mammograms** | Please see the "Physician Home Visits and Office Services" and "Preventive Services" provisions in this Schedule. | |
| **Maternity Services** | Copayments / Coinsurance based on setting where Covered Services are received | Copayments / Coinsurance based on setting where Covered Services are received |
| **Medical Supplies, Durable Medical Equipment and Appliances**<br><br>(Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.) | 15% Coinsurance | 35% Coinsurance |
| NOTE: If durable medical equipment or appliances are obtained through your PCP / SCP or another Network Physician's office, Urgent Care Center Services, Other Outpatient Services, or Home Care Services, the Copayment / Coinsurance listed above will apply in addition to the Copayment / Coinsurance in the setting where Covered Services are received. | | |
| **Nurse Practitioner Services** | Please refer to the "Physician Home Visits and Office Services" provision in this Schedule. | |
| **Outpatient Services** | | |
| **Outpatient Surgery Hospital/Alternative Care Facility** | 15% Coinsurance | 35% Coinsurance |
| **Other Outpatient Services** | 15% Coinsurance | 35% Coinsurance |
| Note: Physical Medicine Therapy obtained through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment / Coinsurance regardless of setting where Covered Services are received. | | |

| | Network | Non-Network |
|---|---|---|
| **Physician Home Visits and Office Services** | | |
| Primary Care Physician (PCP)<br><br>The PCP Copayment / Coinsurance also applies to the following Covered Services regardless of Outpatient setting where they are received:<br><br>• Diagnostic mammograms<br>• Diabetes self management training<br>• Medical nutritional therapy for obesity | **Low Option:** $20 Copayment per visit<br><br>**Medium Option:** $25 Copayment per visit<br><br>**High Option**: $30 Copayment per visit | 35% Coinsurance |
| Specialty Care Physician (SCP) | **Low Option:** $20 Copayment per visit<br><br>**Medium Option:** $25 Copayment per visit<br><br>**High Option**: $30 Copayment per visit | 35% Coinsurance |
| Allergy injections | $5 Copayment per visit | 35% Coinsurance |

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received in a Physician's office are subject to the Other Outpatient Services Copayment / Coinsurance.

The allergy injection Copayment / Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment / Coinsurance will apply if an office visit is billed with an allergy injection.

| | Network | Non-Network |
|---|---|---|
| **Preventive Care Services** | No Copayment / Coinsurance up to the Plan's Maximum Allowable Amount.<br><br>Note: When Childhood Immunizations are received from a Network Provider, Covered Services are not subject to Copayments / Coinsurance. | Copayments / Coinsurance based on setting where Covered Services are received |
| • **Childhood Immunizations** | Benefits are available for Dependents from birth through age 18. | |
| • **Lead Poisoning Screening** | Benefits for lead poisoning screenings are available to Dependents under six (6) years of age. | |
| • **Mammograms** | Routine mammograms are covered under "Preventive Care."<br><br>Non-routine mammograms are covered under "Physician Home Visit & Office Services." | |
| • **Colonoscopies** | Routine colonoscopies are covered under "Preventive Care."<br><br>Non-routine colonoscopies are covered under "Surgery." | |
| **Skilled Nursing Facility Services** | Please refer to the "Inpatient Facility Services" provision in this Schedule. | |
| **Surgery** | Copayments / Coinsurance based on setting where Covered Services are received | Copayments / Coinsurance based on setting where Covered Services are received |
| **Temporomandibular and Craniomandibular Joint Disease Treatment** | Copayments / Coinsurance based on setting where Covered Services are received.<br><br>Nonsurgical and diagnostic services are limited to a combined maximum of $1,250 per Member per Benefit Period. | |
| **Therapy Services** | Copayments / Coinsurance based on setting where Covered Services are received | Copayments / Coinsurance based on setting where Covered Services are received |

NOTE: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will

| | Network | Non-Network |
|---|---|---|
| be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. | | |
| Maximum Visits per Benefit Period for: | | |
| Physical Therapy | 30 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here. | |
| Occupational Therapy | 30 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here. | |
| Speech Therapy | 30 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here. | |
| Manipulation Therapy | 24 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here. | |
| **Urgent Care Center Services** | $50 Copayment per visit | Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowable Amount. |

**Human Organ and Tissue Transplant Services (Bone Marrow/Stem Cell)**

**The Human Organ And Tissue Transplant Services (Bone Marrow/Stem Cell) benefits or requirements described below do not apply to the following:**

- **Cornea transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

**The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services, depending where the service is performed subject to applicable Member cost shares.**

NOTE: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact Us to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)

| Transplant Benefit Period | Network Transplant Provider | Non-Network Transplant Provider |
|---|---|---|
| | Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility. | Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non- Network Transplant Provider Facility. |

| Deductible | Network Transplant Provider | Non-Network Transplant Provider |
|---|---|---|
| | Not applicable | Applicable.<br><br>During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit. |

| Covered Transplant Procedure during the Transplant Benefit Period | Network Transplant Provider Facility | Non-Network Transplant Provider Facility |
|---|---|---|
| • **Precertification required** | During the Transplant Benefit Period, no Copayment / Coinsurance up to the Plan's Maximum Allowable Amount.<br><br>Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed. | During the Transplant Benefit Period, You will pay 50% of the Plan's Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.<br><br>If the Provider is also a Network Provider for the Plan (for services other than Covered Transplant Procedures), then you will **not** be responsible for Covered Transplant Procedures which that exceed the Plan's Maximum Allowable Amount.<br><br>If the Provider is a Non-Network Provider for the Plan, you **will** be responsible for Covered Transplant Procedures which that exceed the Plan's Maximum |

| | | |
|---|---|---|
| | | Allowable Amount.<br><br>Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed. |
| **Covered Transplant Procedure during the Transplant Benefit Period** | **Network Transplant Provider Professional and Ancillary (non-Hospital) Providers** | **Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers** |
| | No Copayment / Coinsurance up to the Plan's Maximum Allowable Amount. | You are responsible for 50% of the Plan's Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit. |
| **Transportation Lodging and Meals** | Covered, as allowed by the Plan, up to a $10,000 per transplant benefit limit. | For Transplants received at a Non-Network Transplant Provider Facility, covered as allowed by the Plan, up to a maximum of $10,000 in charges. You will pay 50% of the approved amount. These charges will NOT apply to your Out-of-Pocket Limit. |
| **Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure** | Covered, as allowed by the Plan, up to a $30,000 per transplant benefit limit | Covered, as allowed by the Plan, up to a $30,000 per transplant benefit limit. You will be responsible for 50% of search charges. These charges will NOT apply to your Out-of-Pocket Limit. |

| | | |
|---|---|---|
| **Live Donor Health Services** | Donor benefits are limited to benefits not available to the donor from any other source. | |
| | Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Plan's Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement. | You will pay 50% of the Plan's Maximum Allowable Amount for medically necessary live organ donor expenses. These charges will NOT apply to your Out-of-Pocket Limit. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement. |

**Prescription Drugs**

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

| | |
|---|---|
| Retail Pharmacy (Network and Non-Network) | 30 |
| Mail Service | 90 |

Prescription Drug Maximum

| | |
|---|---|
| Per Member | $35,000 per Benefit Period |

NOTE: While Prescription Drugs do not accumulate toward the Lifetime Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.

Network Retail Pharmacy Prescription Drug Copayment / Coinsurance:

| | |
|---|---|
| Tier 1 Prescription Drugs | $8 Copayment per Prescription Order |
| Tier 2 Prescription Drugs | 35% Coinsurance (minimum $12 & maximum $75) per Prescription Order |
| Tier 3 Prescription Drugs | 50% Coinsurance (minimum $24 & maximum $150) per Prescription Order |

| | |
|---|---|
| Our Mail Service Program Prescription Drug Copayment / Coinsurance: | |
| Tier 1 Prescription Drugs | $16 Copayment per Prescription Order |
| Tier 2 Prescription Drugs | $40 Copayment per Prescription Order |
| Tier 3 Prescription Drugs | $60 Copayment per Prescription Order |
| Non-Network Retail Pharmacy Prescription Drug Copayment / Coinsurance: | 50% Coinsurance (minimum $30) per Prescription Order. |

NOTE: No Copayment / Coinsurance applies to certain diabetic and asthmatic supplies, up to the Plan's Maximum Allowable Amount when obtained from a Network Pharmacy. These supplies are covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to Prescription Drug Copayments / Coinsurance.

Note: If you request, or your Network Physician or other Network Provider dispenses a Tier 2 or 3 Prescription Drug when a Tier 1 Drug is available, then you will be responsible for payment of the following:

- The difference in price between the Tier 1 Prescription Drug and the equivalent Tier 2 or Tier 3 Prescription Drug, and
- The payment of the Tier 1 Prescription Drug Copayment.

# COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **To receive maximum benefits for Covered Services, care must be received from a Primary Care Physician (PCP), a Specialty Care Physician (SCP), or another Network Provider. Services that are not received from a PCP, SCP, or another Network Provider will be considered a Non-Network service, unless otherwise indicated in this Benefit Booklet.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP, another Network Provider, or a Non-Network Provider.

Please refer to the "How to Obtain Covered Services" section of this Benefit Booklet for additional details about the Plan's requirements.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. The Plan cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

**All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms, and provisions of this Benefit Booklet, including any attachments, riders, and endorsements.** Covered Services must be Medically Necessary and not Experimental / Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Plan, including receipt of care from a PCP, SCP, or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization / Precertification has been obtained. Decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services, and new technology are based on Our clinical coverage guidelines and medical policy. Published peer-review medical literature, opinions of experts, and the recommendations of nationally recognized public and private organizations, which review the medical effectiveness of health care services and technology may also be considered.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. The Plan's payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period Limit/Maximum, or Lifetime Maximum in this Benefit Booklet.**

## Ambulance Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing transportation) designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals (other vehicles that do not meet the above definition, including but not limited to ambulettes, are not Covered Services):

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by Us to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non-Covered Services for Ambulance include but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

## Behavioral Health and Substance Abuse Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Covered Services include the following:

- **Inpatient Services** - Benefits are available for behavioral health or substance abuse treatment provided to a bed patient in a Hospital or any facility which the Plan allows. This includes psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation care.
- **Outpatient Services** - Covered Services also include non-residential services provided to you as well as your spouse, children, parents, grandparents, brothers and sisters and their

spouses, if the services are provided to enhance your treatment. Covered Services for the Subscriber and Dependents include partial hospitalization services, prescribed drugs, convulsive therapy, psychotherapy, and psychological testing.

- **Transitional Care Services** - Benefits are also available for transitional services. Transitional services are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital. Most often, transitional care will be rendered in a day treatment program that provides successive hours of therapy.
- **Court-Ordered Services** - Benefits are available for Medically Necessary Hospital services, Medical Services, and outpatient services for behavioral health or substance abuse treatment rendered to a Member pursuant to an emergency detention, an involuntary commitment, or a court order to the extent benefits would have been available under the Plan.

  Should such services not be rendered by a Network Provider, benefits will be paid to the extent benefits would have been available at the Network Level when:

  1. Services could not have been provided through a Network Provider; and
  2. The Provider or Member, or other person on behalf of the Member, notifies Us within seventy-two (72) hours of the initial provision of such services.

  Upon receipt of such notification, We will arrange for further Medically Necessary services to be furnished by a Network Provider, if you wish benefits to be continued to be paid at the Network Level.

  You may also choose to continue to see Non-Network Providers, but further Medically Necessary services furnished by a Non-Network Provider will be paid at a lower level as indicated in the Schedule of Benefits.

  Reimbursement for services rendered by a Non-Network Providers will be no more than the maximum reimbursement for the services under the state medical assistance program.

## Non-Covered Behavioral Health and Substance Abuse Services (please also see the Exclusions section of this Benefit Booklet for other non-Covered Services)

- Residential Treatment services, unless required by law. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Custodial or domiciliary Care.
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets the Plan's Medical Necessity criteria for Inpatient admission for your condition.
- Services or care provided or billed by a residential treatment center, school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
- Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.

## Cancer Clinical Trials

Benefits are available for services rendered as part of a cancer clinical trial if the services are otherwise Covered Services under the Plan and the clinical trial meets all of the following criteria:

- The purpose of the trial is to test whether the treatment potentially improves the trial participant's health, and is not designed simply to test toxicity or disease pathophysiology;
- The trial does one of the following:
  - Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - Tests responses to a health care service, item, or drug for the treatment of cancer;
  - Compares the effectiveness of health care services, items, or drugs for the treatment of cancer; or
  - Studies new uses of health care services, items, or drugs for the treatment of cancer;
- The trial is approved by one of the following:
  - The National Institute of Health, or one of its cooperative groups or centers under the federal Department of Health and Human Services;
  - The federal Food and Drug Administration;
  - The federal Department of Defense; or
  - The federal Department of Veteran's Affairs.

Benefits do not, however, include the following:

- The health care service, item, or investigational drug that is the subject of the clinical cancer trial;
- Investigational drugs or devices not approved by the federal Food and Drug Administration;
- Any service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient,
- Transportation, lodging, or food expenses associated with travel to the facility providing the cancer clinical trial; or
- Any services, items, or drugs provided during the trial that are provided free of charge or are eligible for reimbursement by a person other than the insurer, including the sponsor of the clinical trial.

## Childhood Immunizations

**Please see the "Preventive Care Services" provision later in this section for details. Also refer to the Schedule of Benefits for payment information.**

## Chiropractor Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Benefits are available for chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.

Non-Covered Services for chiropractic care include, but are not limited to:

- Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
- Nutritional or dietary supplements, including vitamins.
- Cervical pillows.
- Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

## Dental Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

### Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.

- Mandibular / maxillary reconstruction.
- Anesthesia.

### Other Dental Services

Hospital or Ambulatory Surgical Facility charges and anesthetics provided for dental care are covered if the Member meets any of the following conditions:

1) The Member is under the age of nineteen (19);
2) The Member has a chronic disability that is attributable to a mental and/ or physical impairment which results in substantial functional limitation in an area of the Member's major life activity, and the disability is likely to continue indefinitely; or
3) The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

## Diabetes Equipment, Education, and Supplies

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this section. For information on diabetic self-management training services, please refer to the "Preventive Care" provision in this section. For information on Prescription Drug coverage, please refer to the "Prescription Drugs" provision in this section.

## Diagnostic Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.

- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use Our independent laboratory Network Provider called the Reference Laboratory Network (RLN) in order to receive in-network benefits.

When Diagnostic services are performed within 3 days (72 hours) as part of pre-admission testing required for an Inpatient admission or an Outpatient surgery, no Copayment is required. Any Coinsurance will still apply.

When Diagnostic radiology is performed in a Network Physician's Office, no Copayment is required. Any Coinsurance from a Network or a Non-Network Physician will still apply.

## Emergency Care and Urgent Care Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

### Emergency Care (including Emergency Room Services)

Benefits are available for services or supplies that you require in the emergency room to treat an Emergency. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital.

Medically Necessary services that meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours, or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have contract with Us or is a BlueCard Provider, you will be financially responsible for any care determined to be not Medically Necessary.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network service unless the continuation of care is authorized and is Medically Necessary.

### Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Covered Services rendered by a Non-Network Urgent Care Center will be covered as a Network service; however, the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment, or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician directs you

to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

## Home Care Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Evaluation of the need, and development of a plan, for home care by a registered nurse (R.N.), a physician extender, or medical social worker when approved or requested by the attending Physician.
- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional counseling provided by or under the supervision of a registered dietician or a dietician certified under subch. IV of chap. 448 when Medically Necessary as part of the home care plan; and
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when allowed by the Plan, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services. Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services, and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)

- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

**Home infusion therapy** will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

## Hospice Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice, and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment, and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non-Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

## Inpatient Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF), or other Provider for room, board, and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

### Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit allowed by the Plan. The unit must have facilities, equipment, and supportive services for intensive care of critically ill patients.

### Ancillary (Related) Services

- Operating, delivery and treatment rooms, and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts, and splints.
- Diagnostic Services.
- Therapy Services.

### Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exam** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

### Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

## Kidney Disease Treatment

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Benefits are available for kidney disease treatment including dialysis, transplantation, and donor-related services.

**Note:** Members with End Stage Renal Disease (ESRD) should contact Medicare about enrollment and benefit options.

## Lead Poisoning Screening

**Please see the "Preventive Care Services" provision later in this section for details. Also refer to the Schedule of Benefits for payment information.**

## Mammography Examinations

**Please see the "Preventive Care Services" provision later in this section for details. Also refer to the Schedule of Benefits for payment information.**

## Maternity Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that

Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to Us.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copayment.

Under federal law, the Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than forty-eight (48) hours following vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, the Plan may not require that a Provider obtain authorization before prescribing a length of stay which is not in excess of forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours following a cesarean section.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

  1. The antepartum, intrapartum, and postpartum course of the mother and infant;
  2. The gestational stage, birth weight, and clinical condition of the infant;
  3. The demonstrated ability of the mother to care for the infant after discharge; and
  4. The availability of postdischarge follow-up to verify the condition of the infant after discharge.

- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

  1. Parent education;
  2. Assistance and training in breast or bottle feeding; and
  3. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

  At your discretion, this visit may occur at the Physician's office.

## Medical Supplies, Durable Medical Equipment, and Appliances

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

The supplies, equipment, and appliances described below are Covered Services under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as allowed by the Plan. The repair, adjustment, or replacement of the purchased equipment, supply, or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).
- In addition, replacement of purchased equipment, supplies or appliance may be covered if:

    1. The equipment, supply, or appliance is worn out or no longer functions.
    2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
    3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
    4. The equipment, supply, or appliance is damaged and cannot be repaired.

The Plan may establish reasonable quantity limits for certain supplies, equipment, or appliances described below. A detailed listing of supplies, equipment, or appliances that are not covered by the Plan, including quantity limits, is available to you upon request. Please call the customer service number on your Identification Card or visit Our website at www.anthem.com. This list is subject to change.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that are allowed by the Plan are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have the Plan's Prescription Drug benefit or if the supplies, equipment, or appliances are not received

from Our Mail Service or from a Network Pharmacy. These include: Syringes, needles, oxygen, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets
3. Clinitest
4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. The Plan may establish reasonable limits on the number of pairs allowed per Member per Benefit Period.
5. Needles/syringes
6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. Vitamins
6. Medijectors

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental. If the Member owns the equipment, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when allowed by the Plan, based on the Member's condition.

**Non-covered** items may include but are not limited to:

1. Air conditioners
2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

  1. Replace all or part of a missing body part and its adjoining tissues; or
  2. Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.

2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.
7. Routine periodic servicing, such as testing, cleaning, and checking of the device.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage, and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes.
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.
5. Routine periodic servicing, such as testing, cleaning, and checking of the device.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

## Nurse Practitioner Services

Benefits are available for Papanicolaou tests (pap smears), pelvic examinations, and associated diagnostic services provided by a licensed Nurse Practitioner if benefits are available for the services when provided by a Physician. The Nurse Practitioner must be practicing within the scope of his or her license in order for benefits to be covered.

## Outpatient Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as allowed by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services,

surgery, or rehabilitation, or other Provider facility as allowed by the Plan. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

**For Emergency Accident or Medical Care** refer to the **Emergency Care and Urgent Care** section.

## Physician Home Visits and Office Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Covered Services include care provided by a Physician in their office or your home.

**Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections, and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

**Home Visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

**Diagnostic Services** when required to diagnose or monitor a symptom, disease, or condition.

**Surgery and Surgical Services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.

**Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

## Preventive Care Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Preventive Care services include Inpatient services Outpatient services and Physician Home Visits and Office Services. These services may vary based on the age, sex, and personal history of the individual, and as determined appropriate by Our clinical coverage guidelines. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition

are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. (Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.) Examinations include, but are not limited to:

  1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
  2. Adult routine physical examinations.
  3. Pelvic examinations.
  4. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
  5. Annual dilated eye examination for diabetic retinopathy.

- Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follows the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians.

  These include, but are not limited to:

  1. Hepatitis A vaccine.
  2. Hepatitis B vaccine.
  3. Hemophilus influenza b vaccine (Hib).
  4. Influenza virus vaccine.
  5. Rabies vaccine.
  6. Diphtheria, Tetanus, Pertussis vaccine.
  7. Mumps virus vaccine.
  8. Measles virus vaccine.
  9. Rubella virus vaccine.
  10. Poliovirus vaccine.
  11. Varicella (chicken pox) vaccine

- Screening examinations:

  1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, and cataracts.
  2. Routine hearing screening.
  3. Routine screening mammograms.
  4. Routine cytologic and chlamydia screening (including pap test).
  5. Routine bone density testing for women.
  6. Routine prostate specific antigen testing.
  7. Routine colorectal cancer examination and related laboratory tests.
  8. Routine colonoscopies.

**Diabetes Self Management Training** for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

**Medical Nutritional Therapy** limited to consultations for the Medically Necessary management and treatment of obesity under the supervision of a Physician. Any Prescription Drug or medical supply prescribed as a part of this therapy will not be covered except as otherwise stated under the Plan.

## Surgical Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as allowed by the Plan.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, diagnostic colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

## Reconstructive Services

Certain reconstructive services due to disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services are payable only if the original procedures would have been a Covered Service under the Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

## Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy and who elects breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

### Sterilization

Sterilization is a Covered Service.

## Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders. Covered Services include diagnostic procedures and Medically Necessary surgical or non-surgical treatment. Benefits are also available for prescribed intraoral splint therapy devices.

## Therapy Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

### Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. **Non-Covered Services** include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). **Non-Covered Services** include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

### Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning, and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

### Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:

- Admission to a Hospital mainly for physical therapy;
- Long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

## Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

**The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:**

- **Cornea transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.**

**The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.**

### Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and transfusions

as allowed by the Plan including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

### Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Network Transplant Provider Facility.

### Transplant Waiting Period

To be eligible for organ transplant benefits, you must be continuously enrolled under the Plan for a period not less than three hundred sixty-five (365) days. Time served under the Employer's previous plan for a covered transplant will be credited toward the three hundred sixty-five (365) day waiting period. The Plan will only credit time for those transplants that were a covered benefit under the Employer's previous plan.

This waiting period is not the same as a Pre-existing Condition Period nor will Creditable Coverage provisions apply. The waiting period is a separate waiting period for transplants only.

### Prior Approval and Precertification

In order to maximize your benefits, you should call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card **and ask for the transplant coordinator.** Even if a prior approval for the Covered Transplant Procedure is issued, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before the Plan will cover benefits for a transplant. Your Physician must certify, and We, on behalf of the Employer, must agree, that the transplant is Medically Necessary. Your Physician should submit a written request for precertification to Us as soon as possible to start this process. Failure to obtain precertification will result in a denial of benefits.

Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the subsequent

requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

### Transportation, Meals and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your permanent residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility, lodging, and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For meal, lodging, and ground transportation benefits, a maximum benefit will be provided up to the current limits set forth in the Internal Revenue Code.

Non-Covered benefits for transportation, meals, and lodging include, but are not limited to:

- Alcohol, tobacco, or any other non-food item,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically allowed by the Plan,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

**Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.**

## Prescription Drug Benefits

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

The pharmacy benefits available to you under the Plan are managed by Our pharmacy benefits manager (PBM). Our PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, and provides clinical management services.

The management and other services Our PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and operating a Mail Service pharmacy. Our PBM, in consultation with Us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regiments; Drug interactions or Drug/pregnancy concerns. You may review a copy of the current covered Prescription Drug list on Our website at: **www.AnthemPrescription.com.**

You may also request a copy of the covered Prescription Drug list by calling Us at the Customer Service telephone number on the back of your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plan, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system and the pharmacist is instructed to contact Us or Our pharmacy benefits manager. We, or Our PBM, use pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee and reviewed and adopted by Us. We, or Our PBM communicate the results of the decision to the pharmacist. We, or Our PBM may contact your prescribing Physician if additional information is required to determine whether Prior Authorization should be granted.

For a list of the current Drugs requiring Prior Authorization, please contact Us at the Customer Service telephone number on the back of your ID card or consult Our website at: www.AnthemPrescription.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage under your Plan. Refer to the Prescription Drug benefit sections in this Benefit Booklet for information on coverage, limitations, and exclusions. Please ask your Provider or Network Pharmacist to check with Us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

**Therapeutic Substitution of Drugs** is a program approved by Us and managed by Our PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. We, or Our PBM, may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the Prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic Drug substitutes, contact Us by calling the Customer Service telephone number on the back of your ID card. You may also review the list of possible therapeutic Drug substitutes on Our PBM's website at: www.AnthemPrescription.com. The therapeutic Drug substitutes list is subject to periodic review and amendment.

## Step Therapy

Step therapy protocol means that a Member may need to use one type of medication before another. Our PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the Physician will need to submit a letter fax including the following details:

- Member name and ID number;
- Diagnosis;
- Drug name;
- Reason for appeal;
- Physician name, specialty, address, and phone number.

## Covered Prescription Drug Benefits

Covered Services include Prescription legend drugs which:

1) May only be dispensed according to a written Prescription from a Physician, under federal law;
2) Are approved for human use by the Food and Drug Administration; and
3) Are dispensed by a Pharmacist, acting within the scope of his/her license, on or after your Effective Date for your outpatient use.

Covered Services also include any Prescription legend drug that is:

1) Approved by the Food and Drug Administration for the treatment of HIV infection or HIV-related illness;
2) In or has completed a phase 3 clinical investigation; and
3) Prescribed and administered in accordance with the treatment protocol approved for the drug.

Covered services further include:

- Medical supplies for the treatment of diabetes including insulin, blood glucose testing strips, lancets, insulin syringes, and test solutions. Benefits are also available for other Prescription Drugs used to treat diabetes.

  Equipment for the treatment of diabetes including glucometers, insulin infusion pumps and dedicated insulin infusion pump supplies, or related supplies is covered under the "Medical Supplies, Durable Medical Equipment, and Appliances" provision earlier in this section.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact Us to determine approved covered supplies. If certain supplies, equipment, or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment, and Appliances instead of under Prescription Drug benefits.
- Injectables.
- Certain Prescription Legend drugs may be Covered Services if an over the counter equivalent exists. This list is subject to change on a semiannual basis. Please contact Us or check the website at www.anthem.com for the most current listing of medications.

**Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other non Covered Services)**

- Prescription Drugs dispensed by any Mail Service program other than Our Mail Service, unless prohibited by law.
- Prescription Drugs that are Experimental / Investigative. This Exclusion does not apply to any prescription legend drug that is:
  a. Approved by the Food and Drug Administration for the treatment of HIV infection or HIV-related illness;
  b. In or has completed a phase 3 clinical investigation; and
  c. Prescribed and administered in accordance with the treatment protocol approved for the drug.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents, unless noted as covered on the website at www.anthem.com and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product, unless noted as covered on the website at www.anthem.com.
- Off label use, except as otherwise prohibited by law or as allowed by the Plan.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.

- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug that is used primarily for weight loss.
- Drugs not requiring a Prescription by federal law (including Drugs requiring a Prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities that exceed the limits established by the Plan including any age limits.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first (six months) after the product or technology received FDA New Drug Approval or other applicable FDA approval. We, on behalf of the Employer, may waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. **Please contact Us for additional information on these Drugs.**
- Prescription Drugs or other services dispensed to you for purposes other than your own use.
- Nutritional or dietary supplements. This includes, but is not limited to, those supplements that by law do not require either the written Prescription of a Physician or dispensing by a licensed Pharmacist. It also includes food replacements, such as infant formula.

## Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment

will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment. If you receive Covered Services from a Non-Network Pharmacy, a Deductible and Coinsurance/Copayment amount may also apply.

### Days Supply

The number of days supply of a Drug that you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits.

### Tiers

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug has been classified as a first, or second, or third "tier" Drug. The determination of tiers is made based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- Tier 1 generally includes Generic Prescription Drugs.
- Tier 2 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other Drugs.
- Tier 3 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other Drugs in lower tiers.

### Generic Drug Encouragement

We may, from time to time, offer incentives to encourage the use of Generic Drugs. This may involve waiving a Copayment/Coinsurance for certain Generic Drugs for a period of time or other incentives.

### Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, a Non-Network Pharmacy, or Our Mail Service Program. It is also based upon the Tier in which the Prescription Drug has been classified. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

We retain the right, on behalf of the Employer, to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the Plan or Our PBM from Drug manufacturers or similar vendors. For Covered Services provided by a Network Pharmacy or through Our Mail Service, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts.

For Covered Services provided by a Non-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

## How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

**Network Pharmacy** – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Us with a written request for refund.

**Non-Network Pharmacy** – You are responsible for payment of the entire amount charged by the Non-Network Pharmacy. You must submit a Prescription Drug claim form to Us for reimbursement consideration. These forms are available from Us or from the Employer. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to Us. The itemized receipt must show:

- Name and address of the Non-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the prescription;
- Quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Plan's Maximum Allowable Amount.

**Our Mail Service Program** – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to Our Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill.

# NON COVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We, on behalf of the Employer, are the final authority for determining if services or supplies are Medically Necessary.

The Plan does not provide benefits for procedures, equipment, services, supplies, or charges:

1) Which We, on behalf of the Employer, determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

2) Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet, or recognized by the Plan. Examples of non-covered providers include, but are not limited to masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

3) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us, on behalf of the Employer. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if it is deemed to be Experimental / Investigative.

4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

5) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

6) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

7) For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

8) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

9) For court ordered testing or care unless Medically Necessary.

10) For which you have no legal obligation to pay in the absence of this or like coverage.

11) The following charges:

a. Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
b. Surcharges for furnishing and/or receiving medical records and reports.
c. Charges for doing research with Providers not directly responsible for your care.
d. Charges that are not documented in Provider records.
e. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
f. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

12) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

13) Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

14) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

15) For missed or canceled appointments.

16) For mileage, lodging and meals costs, and other Member travel related expenses, except as allowed by the Plan or specifically stated as a Covered Service.

17) For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if a Member had applied for Parts A and/or B, except, as specified elsewhere in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For purposes of the calculation of benefits, if the Member had not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

18) Charges in excess of the Plan's Maximum Allowable Amounts.

19) Incurred prior to your Effective Date.

20) Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.

21) For any procedures, services, Prescription Drugs, equipment, or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change, or improve your appearance or are furnished for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Us on behalf of the Employer, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier / self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

22) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

23) The Plan does not pay services supplies etc for:

a. Custodial Care, convalescent care or rest cures.
b. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
c. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
d. Care provided or billed by residential treatment centers or facilities, unless those centers or facilities are required to be covered by law. This includes but is not limited to individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
e. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
f. Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

24) For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:

- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.
- Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

25) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

26) For dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

27) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

28) For Dental implants.

29) For Dental braces.

30) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of immunosuppresives.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

31) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

32) Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in the "Covered Services" section. Weight loss programs include, but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.

33) For marital counseling.

34) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

35) For vision orthoptic training.

36) For hearing aids or examinations for prescribing or fitting them.

37) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

38) For reversal of sterilization.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis.

40) For personal hygiene, environmental control, or convenience items including but not limited to:

a. Air conditioners, humidifiers, air purifiers;
b. Physical fitness equipment such as a treadmill or exercise cycles;
c. Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
d. Charges from a health spa or similar facility;
e. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
f. Charges for non-medical self-care except as otherwise stated;
g. Purchase or rental of supplies for common household use, such as water purifiers;
h. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
i. Infant helmets to treat positional plagiocephaly;
j. Safety helmets for Members with neuromuscular diseases; or
k. Sports helmets.

41) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or allowed by the Plan.

42) For care received in an emergency room that is not Emergency Care, except as specified in this Benefit Booklet. This includes, but is not limited to, suture removal in an emergency room.

43) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

44) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

45) For examinations relating to research screenings.

46) For stand-by charges of a Physician.

47) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

48) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

49) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal, and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

50) For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.

51) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. We, on behalf of the Employer, may, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

52) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

53) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

54) Maternity services for a Dependent daughter.

55) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

56) For hiring, or the services of, a surrogate mother.

57) For surgical treatment of gynecomastia.

58) For treatment of hyperhydrosis (excessive sweating).

59) For any service for which you are responsible under the terms of this Benefit Booklet to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

60) Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.

61) Services, supplies, and equipment for the following:
   a. Gastric electrical stimulation.
   b. Hippotherapy.
   c. Intestinal rehabilitation therapy.
   d. Prolotherapy.
   e. Recreational therapy.
   f. Sensory integration therapy (SIT).

62) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

63) Complications directly related to a service or treatment that is a non Covered Service under this Benefit Booklet because it was determined by Us, on behalf of the Employer, to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non

Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

64) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply.

65) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

66) Treatment of telangiectatic dermal veins (spider veins) by any method.

67) The following allergy tests and treatment:

a. IgE RAST tests unless intradermal tests are contraindicated.
b. Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
c. Food allergy test panels (including SAGE food allergy panels).
d. Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

68) Reconstructive services except as specifically stated in the "Covered Services" section of this Benefit Booklet, or as required by law.

# ELIGIBILITY AND ENROLLMENT

You have coverage provided under the Plan because of your employment with / membership with / retirement from the Employer. You must satisfy certain requirements to participate in the Plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by Your Employer or state and/or federal law and allowed by the Plan.

**Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.**

## Eligibility

The following eligibility rules apply unless you are notified by Us and the Employer.

### Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be either: An employee, member, or retiree of the Employer, and:
- Be entitled to participate in the benefit Plan arranged by the Employer;
- Have satisfied any probationary or waiting period established by the Employer and (for non-retirees) be Actively At Work performing the duties of your principal occupation for the Employer at least thirty-six (36) hours per week;

### Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Employer and be:

- The Subscriber's spouse as recognized under the laws of the state where the Subscriber lives.
- The Subscriber's or the Subscriber's spouse's unmarried children, including natural children, stepchildren, newborn and legally adopted children and children who the Employer has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- Unmarried children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.
- A child of a covered Dependent (i.e., a grandchild of the covered Subscriber or the Subscriber's covered spouse) claimed as a Dependent for IRS purposes until the child reaches

age twenty-five (25). The grandparent must have legal guardianship of the grandchild in order for the grandchild to be eligible for benefits.

- You may not participate in this Plan as both a Subscriber and a Dependent, and your Dependents may not participate in this Plan as a Dependent of more than one Subscriber.

All enrolled eligible, unmarried children will continue to be covered until the age limit listed in the Schedule of Benefits.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, the Plan may require that the Subscriber complete a "Dependency Affidavit" and provide a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under the Plan.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by law.

## Enrollment

### Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Employer. The application must be received within thirty-one (31) days of the Subscriber's initial eligibility. Your Effective Date will be one month after date of hire. If the initial application is not received within thirty-one (31) days of initial eligibility, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on Eligible Dependents.

### Newborn Child Coverage

Your newborn child is not covered under the plan unless properly enrolled within 30 days of the date of birth. If your child is properly enrolled, coverage will begin on the date of the child's birth.

### Adopted Child Coverage

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

If Family Coverage is not already in force, your Dependent's Effective Date will be the date of the adoption or placement for adoption, if you send the Employer the completed change form within thirty-one (31) days of the event.

### Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If an application is not received within the 31-day period, the child will be treated as a Late Enrollee.

### Qualified Medical Child Support Order

If you are ordered to provide coverage for a child under a health insurance plan pursuant to a qualified medical child support order (QMCSO) and you are eligible for family coverage under the plan, you may enroll such child in the plan without respect to the plan's annual open enrollment period. If you are ordered to provide coverage for a child, you should immediately send a copy of the order to the Employer. The Employer will determine whether the order is a QMCSO or if it is otherwise binding on the plan. The Employer will make this determination based upon its written QMCSO procedures and it will notify you when it receives a proposed order and when it has decided whether such an order is a QMCSO. The child will be covered under the plan only after the Employer determines that an order is a QMCSO or is otherwise binding. If necessary, you may also need to complete appropriate enrollment forms or other paperwork before the coverage will begin. In no event will the plan pay or reimburse you, your spouse, or any third party for medical expenses incurred with respect to such child before the Employer approves the order and you submit any necessary paperwork. Coverage of any pre-existing condition of a child enrolled under this provision shall be subject to the plan's pre-existing condition limitations. You should contact the Employer if you would like to receive a copy of their QMCSO procedures.

### Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in the Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan,

provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If an application to add your Dependent or an Eligible Person and Dependent is received more than 31 days after the qualifying event, We will not be able to enroll that person until the Employer's next Open Enrollment. Application forms are available from the Employer.

### Open Enrollment Period

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Employer's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior the Employer's renewal date) which is held no less frequently than once in any 12 consecutive months.

### Notice of Changes

The Subscriber is responsible for notifying the Employer of any changes that will affect his or her eligibility or that of Dependents for services or benefits under the Plan. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. Failure to notify the Employer of persons no longer eligible for services will not obligate the Plan to pay for such services. Acceptance of payments from the Employer for persons no longer eligible for services will not obligate the Plan to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Employer must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the date in which the Member ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

### Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, or age.

## Effective Date of Coverage

You will not be covered by the Plan until your Effective Date. Unless the Plan states otherwise, the Subscriber must be Actively at Work on the day his / her coverage is to become effective.

If you apply for Family Coverage with your own application, the Effective Date for your Dependents will be the same as your Effective Date. If you apply for coverage for your Dependents at a different time, their Effective Dates will differ.

### Statements and Forms

Subscribers (or applicants for membership) must complete and submit applications, medical review questionnaires, or other forms or statements the Plan may reasonably require.

Applicants for membership understand that all rights to benefits under the Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the "Changes in Coverage: Termination & Continuation" section. The Plan will not use a statement made by a Member to void the Member's contract after coverage has been in effect for two (2) years. This does not apply, however, to fraudulent misstatements.

### Delivery of Documents

We will provide an Identification Card for each Member and the Employer will provide a Benefit Booklet for each Subscriber.

# CHANGES IN COVERAGE: TERMINATION & CONTINUATION

## Termination

Except as otherwise provided, your coverage may terminate in the following situations.

- Your coverage will terminate on the date the Administrative Services Agreement between the Employer and Us terminates. If your coverage is through an association, your coverage will terminate on the date the Administrative Services Agreement between the association and Us terminates, or on the date your Employer leaves the association. It will be the Employer's / association's responsibility to notify you of the termination of coverage.

- If you terminate your coverage, termination will be effective on the date your Employer determines you are no longer eligible.

- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in the Plan, your coverage will terminate on the date you cease to be eligible. You must notify the Employer and Us immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you engage in fraudulent conduct or furnish the Plan fraudulent or misleading material information relating to claims or application for coverage, then the Employer may terminate your coverage immediately, retroactive to the date of the fraud or material misrepresentation. You are responsible to pay the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fees paid for such services. On the date your coverage is terminated, the Employer will also terminate your Dependent's coverage.

- A Dependent's coverage will terminate on the date that the person no longer meets the definition of Dependent, except when indicated otherwise in this Benefit Booklet.

- If you elect coverage under another carrier's health benefit plan which is offered by, through, or in connection with the Employer as an option instead of this plan, then coverage for you and your Dependents will terminate on the date you become effective with the other plan, subject to the consent of the Employer. The Employer agrees to immediately notify Us that you have elected coverage elsewhere.

- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Fees, the Employer may terminate your coverage and may also terminate the coverage of all your Dependents.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

- If you are a qualifying retiree, your coverage will end on the date you become eligible for Medicare.

## Removal of Members

Upon written request through the Employer, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

## Reinstatement

You will not be reinstated automatically if coverage is terminated, except as indicated below. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the Employer's request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Employer's clerical error. However, the Employer is liable to Us if We incur financial loss as a result of the Employer's clerical error.

Following a military leave, if you return or request re-employment within the statutory period, coverage will be reinstated on the date you return. Please see the section "Continuation of Coverage Due to Military Service" later in this section for further details.

## Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another group health plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. Certifications may be requested from Customer Service within 24 months of losing coverage. If you have any questions, contact the Customer Service telephone number listed on the back of your Identification Card.

## Continuation

### Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a plan that is subject to the requirements of the

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health plan. It can also become available to other Members of your family, who are covered under the Employer's health plan, when they would otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Employer's health plan, you should contact the Employer.

**COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of health coverage under the Employer's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, the Employer must offer COBRA continuation coverage to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Employer's health plan is lost because of the qualifying event. Under the Employer's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Employer's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Employer's health plan as a "Dependent child."

**If Your Employer Offers Retirement Coverage**

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Employer's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Employer's health plan.

**When is COBRA Coverage Available**

COBRA continuation coverage will be offered to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then the Employer will notify the COBRA Administrator (e.g., Human Resources, external vendor) of the qualifying event.

**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 60 days after the qualifying event occurs.

**How is COBRA Coverage Provided**

Once the Employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for

qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Employer's health plan is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Employer. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Employer's health plan had the first qualifying event not occurred.

**Trade Act of 1974**

Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their group health plan coverage ended.

If you, the Subscriber, qualify for assistance under the Trade Act of 1974, you should contact the Employer for additional information. You must contact the Employer promptly after qualifying for assistance under the Trade Act of 1974 or you will lose these special COBRA rights.

**Fees and the End of COBRA Coverage**

Fees will be no more than 102% of the Employer rate (if your coverage continues beyond eighteen (18) months because of a disability. In that case, Fees in the 19th through 29th months may be 150% of the Employer rate).

Continued coverage ends earlier if the plan ends or if the person covered:

- Fails to pay Fees timely;
- After the date of election, first becomes covered under another group health plan which contains no pre-existing condition limitations or exclusions;
- After the date of election, first becomes covered under another group health plan which contains a pre-existing condition limitation or exclusion which you have satisfied pursuant to the federal Health Insurance Portability and Accountability Act of 1996, as first enacted or later amended; or
- After the date of election, first becomes entitled to Medicare benefits.

**If You Have Questions**

Questions concerning your Employer's health plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. Employers must provide a cumulative total of five (5) years, and in certain instances more than five (5) years, of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by the Act, the law requires employers to continue to provide coverage under the Plan for its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

**Maximum Period of Coverage During Military Leave**

Continued coverage under USERRA will terminate on the earlier of the following events:

1) The date you fail to return to Active Work with the Employer following completion of your military leave. Employees must return to Active Work within:
   a. The first full business day after completing military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service.
   b. Fourteen (14) days after completing military service for leaves of thirty-one (31) to one hundred eighty (180) days,
   c. Ninety (90) days after completing military service, for leaves of more than one hundred eighty (180) days; or
2) Twenty-four (24) months from the date your leave began.

**Reinstatement of Coverage Following a Military Leave**

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under the Plan if you return within:

1. The first full business day of completing your military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. Fourteen (14) days of completing your military service, for leaves of thirty-one (31) to one hundred eighty (180) days; or
3. Ninety (90) days of completing your military service, for leaves of more than one hundred eighty (180) days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to Active Work within the times stated above, you may take up to:

1. Two (2) years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two (2) years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before and the Pre-existing Condition Limitation Period will be credited as if you had been continually covered under the Plan from your original Effective Date.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, the Plan will not provide coverage for any illness or injury caused or aggravated by your military service, as indicated in the "Non-Covered Services / Exclusions" section.

## Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Employer must provide evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

# HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Service from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP, or another Network Provider are considered a Non-Network Service, unless otherwise indicated in this Benefit Booklet.** Contact Us to be sure that Prior Authorization and/or precertification has been obtained.

## Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider benefits will be paid at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. We, on behalf of the Employer, have final authority to determine the Medical Necessity of the service.

- **Network Providers** - include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange your health care services. SCP's are Network Physicians who provide specialty medical services not normally provided by a PCP.

  For services rendered by Network Providers:

  1. You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Coinsurance, Copayments, and/or Deductibles. You may be billed by your Network Provider(s) for any non-Covered Services you receive or when you have not acted in accordance with the Plan.

  2. Health Care Management is the responsibility of the Network Provider.

  If a network is not available for a Covered Service (e.g., anesthesia services, dental services, and hospice services), benefits for that Covered Service will be paid at the Network level, subject to in-network Copayments / Deductibles / Coinsurance, up to the Plan's Maximum Allowable Amount. You may also be billed for charges that exceed the Plan's Maximum Allowable Amount. Please contact Us to determine if a Network Provider is available.

## Non-Network Services

Services which are not obtained from a PCP, SCP, or another Network Provider will be considered a Non-Network Service, unless otherwise indicated in this Benefit Booklet.

For services rendered by a Non-Network Provider, you are responsible for:

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non-Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

## The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, We participate in a program called "BlueCard." This program allows you to receive Covered Services at the In-Network level when you are traveling out of state and need medical care, as long as you use a BlueCard Provider. All you have to do is present your identification card to a participating Blue Cross & Blue Shield Provider, and they will submit your claims to Us.

If you are out of state and an emergency or urgent situation arises, you should receive treatment right away.

In a non-emergency situation, you can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call Bluecard Access at 1-800-810-BLUE.

You can also access doctors and hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

## Relationship of Parties (Plan - Network Providers)

The relationship between Us and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of Us, nor are We, or any of Our employees, an employee or agent of Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under your plan.

We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or Us.

## Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services, or supplies.

## Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Fees for this Plan has the right to services or benefits under the Plan. If anyone receives services or benefits to which they are not entitled to under the terms of the Plan, he/she is responsible for the actual cost of the services or benefits.

## Continuity of Care

If a Network Provider who has provided Covered Services to you terminates his or her agreement with Us, please contact Our Customer Service Department. We have procedures in place that will allow you to continue to see that Provider for a limited time. We can also assist you in selecting another Network Provider to provide your care.

# CLAIMS PAYMENT

When you receive care through a Network Provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

A claim must be filed for you to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit your claim for you. If you submit the claim, use a claim form.

## How Benefits Are Paid

### Maximum Allowable Amount

The amount that We, on behalf of the Employer, or Our Subcontractor, determine is the maximum payable for Covered Services you receive. Generally, to determine the Maximum Allowable Amount for a Covered Service, We or Our Subcontractor use, in addition to other information, internally developed fee schedules.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement for this product, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider, even if the Provider has a participation agreement with Us for another product, the Maximum Allowable Amount is the lesser of the actual charge or the rate under the Managed Care Fee Schedule used with Network Providers for this product.

It is your obligation to pay any Coinsurance, Copayments and Deductibles, and any amounts that exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its participation agreement with Us.

### Member Share of Cost

What you pay often depends on the type of service you receive and if you use a Network or Non-Network Provider. Refer to the "Schedule of Benefits" section of this Benefit Booklet to see what amount you are required to pay for each Covered Service.

This Plan shares the cost of your medical expenses with you up to a pre-determined amount, or the Maximum Allowable Amount. The Plan will not pay any portion of any charge that exceeds this amount.

Services may be subject to a Coinsurance, Copayment, and/or Deductible, as outlined in the Schedule of Benefits. Deductibles and Coinsurance will be based on the Maximum Allowable Amount. Copayments are your share of the cost for Covered Services, and generally must be paid at the time you receive the Covered Services. The Plan pays the share of the balance up to the Maximum Allowed Amount.

Network Providers will seek payment from the Plan for Covered Services for the Maximum Allowable Amount, and will accept this amount as full payment.

You should be aware that when you elect to utilize the services of a Non-Network Provider for a Covered Service, benefit payments to the Non-Network Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to the Plan's Maximum Allowable Amount. **You risk paying more than the Coinsurance, Deductible, and Copayment amount defined in this Benefit Booklet after the Plan has paid its required portion.**

Non-Network Providers may bill you any amount up to the billed charge after the Plan has paid its portion of the bill. Network Providers have agreed to accept discounted payment for Covered Services with no additional billing to you other than Copayment, Coinsurance, and Deductible amounts. You may obtain further information about the network status of a Provider and information on out-of-pocket expenses by calling the number on your Identification Card or by visiting Our website at www.anthem.com.

However, these guidelines change when you receive Covered Services in a Network Provider facility, but from a Non-Network Provider. If you receive Covered Services in a Network Provider facility from a Non-Network Provider such as an anesthesiologist who is employed by or contracted with that Network Facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider's participation agreement for this product. You may be liable for the difference between the billed charge and the Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The Plan will not pay any portion of any charge that exceeds the Maximum Allowable Amount.

## Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to

receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, the Plan will not honor a request to withhold payment of the claims submitted.

## Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Maximum Allowable Amount. If services are performed by Non-Network Providers, then you are responsible for any amounts charged in excess of the Maximum Allowable Amount. Contact Us for more information.

## Assignment

The Employer cannot legally transfer this Benefit Booklet, without obtaining written permission from Us. Members cannot legally transfer the coverage. Benefits available under this Benefit Booklet are not assignable by any Member without obtaining written permission from Us, unless in a way described in this Benefit Booklet.

## Notice of Claim & Proof of Loss

This Plan is not liable, unless We receive written notice that Covered Services have been given to you. The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given. **If We are unable to complete processing of a claim because you or your Provider fail to provide Us with the additional information within 60 days of Our request, the claim may be denied.**

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends,

and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

## Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to Us, or contact customer service and ask for claim forms to be sent to you. If you do not receive the claim forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

## Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be required by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

## Explanation of Benefits (EOB)

After you receive medical care, you will generally receive an explanation of benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible (if any).
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

## BlueCard Program

Under the BlueCard Program, when you obtain health care services outside the geographic area We serve, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or

- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto Us.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, We would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card or go to www.anthem.com for more information about such arrangements.

# HEALTH CARE MANAGEMENT

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources through Case Management and through Precertification review requirements which may be conducted either prospectively (Prospective Review), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management or to determine which services require Precertification, call the Precertification telephone number on the back of your Identification Card or refer to Our website, www.anthem.com.

Members are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information relevant to the Member's Precertification request.

Your right to benefits for Covered Services provided under the Plan is subject to certain policies, guidelines and limitations, including, but not limited to, Our clinical coverage guidelines, medical policy, and Health Care Management features listed in this section.

A description of each Health Care Management feature, its purpose, requirements, and its effects on benefits is provided in this section.

## Clinical Coverage Guidelines

Our clinical coverage guidelines such as medical policy, preventive care clinical coverage guidelines, Precertification review guidelines, Concurrent review guidelines, and Retrospective review guidelines, reflect the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of clinical coverage guidelines is to assist in the interpretation of Medical Necessity. However, the Benefit Booklet and Administrative Services Agreement take precedence over the clinical coverage guidelines. Medical technology and standards of care are constantly changing and We reserve the right to review and update the clinical coverage guidelines periodically.

## Precertification

**NOTICE: Precertification does NOT guarantee coverage for or the payment of the service or procedure reviewed. It is a confirmation of Medical Necessity only.**

**Precertification** is a Health Care Management feature that requires an approval be obtained from Us before incurring expenses for certain Covered Services. Our procedures and timeframes

for making decisions for Precertification requests differ depending on when the request is received and the type of service that is the subject of the Precertification request.

**Urgent Review** means a review for medical care or treatment that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment, or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment. We, applying the prudent layperson standard, may determine that an Urgent Review should be conducted. Depending on the circumstances, Concurrent reviews of continued Hospital stays will typically be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay for Inpatient admissions will be determined. Medical Necessity includes a review of both the services and the setting. The care will be covered according to your benefits for the number of days approved unless Our Concurrent review determines that the number of days should be revised. If a request is denied, the Provider may request reconsideration. Our Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the Member's health requires an earlier decision.

Most Providers know which services require Precertification and will obtain any required Precertification. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. Generally, the ordering Provider, facility or attending Physician will call to request a Precertification review ("requesting Provider"). We will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific Precertification request. The authorized representative can be anyone who is 18 years or older. For Urgent Reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on the process for designating an authorized representative, call the **Precertification telephone number** on the back of your Identification Card.

**You are responsible for obtaining Precertification for certain services you obtain:**

- **From a Non-Network Provider; or**
- **From a Network Provider through the local Blue Cross and Blue Shield Plan if you are traveling or you live outside of the Service Area.**

**When it is your responsibility to obtain Precertification, you should either:**

- **Verify that the Non-Network or Blue Card Provider obtains the required Precertification; or**
- **Obtain the required Precertification yourself.**

**If the required Precertification is not obtained, a Retrospective review will be done to determine if your care was Medically Necessary. If it is determined the services you receive are not Medically Necessary under your Plan and you received your care from a BlueCard Provider or a Provider that does not have a participation agreement with Us, you will be financially responsible for the services.**

For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a participation agreement with Us or is a BlueCard Provider, you will be financially responsible for any care that is determined to be not Medically Necessary.

For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

## Precertification Procedures

**Prospective review** means a review of a request for Precertification that is conducted prior to a Member's Hospital admission, procedure, or course of treatment. For Prospective reviews, a decision will be made and telephone notice of the decision will be provided to the requesting Provider, as soon as possible, taking into account the medical circumstances.

For Urgent reviews, telephone notice will be provided to the requesting Provider as soon as possible taking into account the medical urgency of the situation, but not later than two calendar days from the time the request is received by Us.

If additional information is needed to certify benefits for services, We will notify the requesting Provider by telephone and send written notification to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review. For Urgent Reviews, We will notify the requesting Provider by telephone of the specific information necessary to complete the review within 24 hours after receipt of the request by Us. Written notice will be sent following the request by telephone.

The requested information must be provided to Us within 45 calendar days from receipt of Our request. For Urgent Reviews, the requested information must be provided within 48 hours after Our request for specific information. A decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible.

If a response to Our request for specific information is not received or is not complete, a decision will be made based upon the information in Our possession and telephone notice of the decision will be provided to the requesting Provider. Written notice of Prospective review decisions will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

## Concurrent Review

**Concurrent review** means a review of a request for Precertification that is conducted during a Member's Inpatient Hospital stay or course of treatment. As a result of Concurrent review, additional benefits may be approved for care that exceeds the benefit(s) originally authorized by Our Health Care Management staff.

If a request for Concurrent review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for Urgent Review, a decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by Us. If the request is not received within 24 hours prior to the end of the approved care, the decision will be made and telephone notice of the decision will be provided to the requesting Provider within two calendar days, but no greater than one business day, from the time the request is received by Us.

For Concurrent reviews that do not qualify for Urgent Review, the decision will be made and telephone notice will be provided to the requesting Provider in accordance with the guidelines for Prospective reviews (see sections above.)

If additional information is needed to certify benefits for services for a Concurrent review that does not qualify for Urgent review, We will notify the requesting Provider by telephone and will send written notice to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review. You or your authorized representative and the requesting Provider have 45 calendar days from receipt of Our request to provide the information to Us. A decision will be made and telephone notice of the decision will be provided to the requesting Provider within two business days from the time the requested information is received by Us. If a response to Our request for specific information is not received or is not complete, a decision will be made based upon the information in Our possession and telephone notice of the decision will be provided to the requesting Provider not later than two business days after expiration of the period to submit the requested information.

Written notice of Concurrent review decisions will be sent to you or your authorized representative and the Provider(s) within two business days of the date the decision is rendered.

The Plan will not reduce or terminate **a previously approved** on-going course of treatment until you or your authorized representative receive telephone notice of the decision and have an opportunity to appeal the decision and receive notice of the appeal decision.

## Retrospective Review

**Retrospective review** means a Medical Necessity review that is conducted after health care services have been provided to a Member. If Precertification is required but not obtained prior to the service being rendered, Retrospective review will be conducted. Further, if a service is

subject to a clinical guideline, but Precertification is not required for that service, a Retrospective review may be conducted.

Retrospective review is typically completed after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

For Retrospective review, a decision will be made within 30 calendar days from the time the claim is received by Us (post-claim). Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within 30 calendar days from the time the claim is received by Us (post-claim).

If additional information is needed to certify benefits for services, We will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within 30 calendar days after receipt of the claim (post-claim).

For post-claim Retrospective reviews, you or your authorized representative and the requesting Provider have a reasonable amount of time taking into account the circumstances, but not less than 45 calendar days from the date of Our request to provide the additional information to Us. A decision will be made within 30 calendar days from the time the requested information is received by Us. Written notice of the decision will be provided to you or your authorized representative and the Provider(s).

## Case Management (Includes Discharge Planning)

Case management is a health care management feature designed to promote the most appropriate and cost effective care setting. This feature allows Us to customize your benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by Our health care management staff. In managing your care, We have the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

# APPEALS PROCESS

We want your experience with the Plan to be as positive as possible. There may be times, however, when you have a complaint. During those times, you can contact Our Customer Service Department. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal.

An appeal must be requested in writing and must be received by Us within 180 days after receiving notification of the payment of denial of benefits. The appeal must be identified as a claim appeal and must provide pertinent information such as your Subscriber identification number, patient's name, date, and place of service, and reason for requesting the review. The appeal should be sent to the following address:

Anthem Blue Cross and Blue Shield
Attn: Appeals Department
P.O. Box 33200
Louisville, KY 40232-3200

We will review the appeal once We receive your request. We will send you a notice of Our decision and Our reasons for it within sixty (60) days after receiving the request, unless a shorter time period is required by law.

## Legal Action

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after the Administrator receives the claim or other request for benefits and within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure before filing a lawsuit or other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

# GENERAL PROVISIONS

## Entire Agreement

This Benefit Booklet, Administrative Services Agreement, the Employer's application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire agreement between the Employer and Us and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to Us by the Employer and any and all statements made to the Employer by Us are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Plan, shall be used in defense to a claim under this Plan.

## Form or Content of Benefit Booklet

No agent or employee of Ours is authorized to change the form or content of this Benefit Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem Blue Cross and Blue Shield.

## Allowable Amount Verification

You may contact Our Customer Service Department prior to having a procedure performed to determine if the Provider's estimated charge is within the Plan's Maximum Allowable Amount. You must provide Us with the following information:

1. Date of service;
2. Place of service;
3. Valid 5 digit CPT or ADA procedure code; and
4. Provider's estimated charge.

## Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under the Plan are delayed or considered impractical. Under such circumstances, health care services covered by the Plan and Network providers will be provided as far as is practical under the circumstances, and according to their best judgment. However, the Plan and Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of the Plan.

## Coordination of Benefits

When a Member is covered by two or more plans, We coordinate benefits between them -- except when Medicare's secondary payer rules require Us to do otherwise. The process of determining benefits when multiple plans are involved is commonly referred to as coordination of benefits (COB).

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, we refer to your plan as "This Plan" and any other plan as "Plan." In the rest of the Benefit Booklet, Plan has the meaning listed in the "Definitions" section.

If you are covered under more than one Plan, benefits are calculated based on the rules listed below under "Order of Benefit Determination Rules." The rules specify whether the benefits of your Plan should be determined before or after those of another Plan.

The benefits of your Plan (i.e., This Plan):

1. Are not reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
2. May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in "Effect on the Benefits of This Plan" below.

When used in this section only, these terms have the following meanings:

**Allowable Expense** means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered both an Allowable Expense and a benefit paid.

**Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which you have no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

**Plan** means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous twenty-four (24) hour coverage. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
3. "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

Each contract or other arrangement for coverage under 1. or 2. above is a separate Plan. If an arrangement has two parts and these rules apply only to one of the two, each of the parts is a separate Plan.

**Primary Plan/Secondary Plan** means the "Order Of Benefit Determination Rules" section states whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering you. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When there are more than two Plans covering you, This Plan may be a Primary Plan in relationship to one or more other Plans and may be a Secondary Plan in relationship to a different Plan or Plans.

**This Plan** means the part of this Plan that provides benefits for health care expenses.

### Order of Benefit Determination Rules

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. **Non-Dependent/Dependent.** The benefits of the Plan that covers you as an employee, Member or Subscriber (that is, other than as a Dependent) are determined before those of the Plan that covers you as a Dependent.

2. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in rule 3 (below), when This Plan and another Plan cover the same child as a Dependent of different persons (called "parents"):

   a. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

   b. If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

   However, if the other Plan does not have the rule described in a. but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the Plan of the parent with custody of the child;

   b. Then, the Plan of the spouse of the parent with custody of the child; and

   c. Finally, the Plan of the parent not having custody of the child.

   Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses, or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the Dependent child shall be determined according to rule 2 (above).

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Active/Inactive Employee.** The benefits of a Plan which covers you as an employee or as a Dependent of an employee who is neither laid off nor retired are determined before those of a Plan which covers you as a former employee or as a Dependent of a former employee. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Continuation Coverage.** The benefits of a Plan that covers you as an employee, Member or Subscriber, or as a Dependent of such a person, are determined before those of a Plan that covers you as a person on state or federal continuation. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered you, as a Member or Subscriber, for the longer period are determined before those of the Plan which covered you for the shorter time.

### Effect on the Benefits of This Plan

This section applies when, in accordance with the order of benefit determination rules, This Plan is a Secondary Plan in relationship to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to below as "the other Plans."

The benefits of This Plan will be reduced when the Allowable Expenses in a Claim Determination Period are less than the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this section; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

### Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need. We may obtain needed facts from, or give them to, any other organization or person. We need not tell or obtain your consent to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

### Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

### Right of Recovery

If the amount of the payments This Plan made is more than This Plan should have paid under this section, This Plan may recover the excess from one or more of:

1. The persons This Plan has paid or for whom This Plan has paid;

2. Insurance companies; or
3. Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

## Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.

## Physical Examination

When a claim is pending, the Plan reserves the right to request a Member to be examined by an applicable Provider. This will be requested as often as reasonably required.

## Worker's Compensation

The benefits under the Plan are not designed to duplicate benefits that Members are eligible for under the Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to a Member shall be paid back by, or on behalf of, the Member to the Plan if the Plan has made or makes payment for the services received. It is understood that coverage under the Plan does not replace or affect any Worker's Compensation coverage requirements.

## Other Government Programs

The benefits under the Plan shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

## Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

### Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your injuries. The following apply:

- The Plan has first priority for the full amount of benefits it has paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice them.
- The Plan has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim still held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, other expenses or costs you incur without the Plan's prior written consent. The Plan further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

### Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse the Plan to the extent of benefits the Plan paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or

costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

  1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.

- In the event that you fail to disclose to the Plan the amount of your settlement, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan would not have any obligation to pay the Provider.

- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

## Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred, and all information regarding the parties involved.

- You must give the Plan an opportunity to participate in any pursuit of a Recovery from any party.

- You must cooperate with the Plan in the investigation, settlement, and protection of the Plan's rights.

- You must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

- You shall not enter into any settlement agreement with any party without the Plan's prior written consent.

## Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

## Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Worker's Compensation or Employer Liability Law, the value of Covered Services shall be the amount the Plan paid for the Covered Services.

## Transfer of Benefits

Only you, the Subscriber, and your Dependents, as shown on Our records, are entitled to Plan benefits. These rights are forfeited if you or any of your Dependents:

1. Transfer those rights; or
2. Aid any person in fraudulently obtaining Plan benefits.

You and your Dependents must reimburse the Plan for any benefits the Plan has paid in this context.

## Relationship of Parties (Employer-Member Plan)

Neither the Employer nor any Member is the agent or representative of Anthem Blue Cross and Blue Shield.

The Employer is responsible for passing information to the Member. For example, if We give notice to the Employer, it is the Employer's responsibility to pass that information to the Member. The Employer is also responsible for passing eligibility data to Us in a timely manner. If the Employer does not provide Us with timely enrollment and termination information, We are not responsible for the administration of claims for Covered Services for Members.

## Important Note

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Booklet and Administrative Services Agreement constitutes a contract solely between the Employer and Blue Cross Blue Shield of Wisconsin, dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Wisconsin. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

## Modifications

This Benefit Booklet allows the Employer to make the Plan coverage available to eligible Members. However, this Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Administrative Services Agreement, or by mutual agreement between the Employer and Us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice We provide to the Employer about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Benefit Booklet.

## Conformity with Law

Any provision of this Plan which is in conflict with federal law is hereby automatically amended to conform with the minimum requirements of such laws.

## Clerical Error

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or Us.

## Policies and Procedures

The Plan is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Services Agreement, the Administrator has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Benefit Booklet. The Administrator reserves the right to discontinue a pilot or test program at any time. The Administrator will provide advance written notice to the Employer of the introduction or termination of any such program.

## Waiver

No agent or other person, except an authorized officer of the Plan, is able to disregard any conditions or restrictions contained in this Benefit Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

## Plan's Sole Discretion

The Plan may cover services and supplies not specifically described in the Benefit Booklet if We determine such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

## Reservation of Discretionary Authority

The following provision only applies where the interpretation of the Plan is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We shall have all powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of the Plan and the interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. We have complete discretion to interpret the Benefit Booklet. Our determination shall

be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

The Member may request an advance determination as to whether a treatment, service, or supply is a Covered Service by submitting a request in writing to Our Customer Service Department. Where prior written approval is given, the Plan will pay benefits if, at the time the treatment, service or supply is provided the Member's coverage is in force and the Plan's approval has not expired.

If benefit levels change under this Plan, you are entitled to the level of benefits in effect on the date services or supplies were rendered.

# DEFINITIONS

If a word or phrase in this Benefit Booklet has a special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact the customer service number located on the back of your ID Card or submit your question online at www.anthem.com.

**Actively At Work** – An employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

**Administrative Services Agreement** - The agreement between the Administrator and the Employer regarding the administration of certain elements of health care benefits of the Employer's group health plan.

**Administrator** - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is Blue Cross Blue Shield of Wisconsin dba Anthem Blue Cross and Blue Shield. ***The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.***

**Benefit Booklet** - This summary of terms of your health benefits.

**Benefit Period** – The length of time that the Plan will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before this length of time, then the Benefit Period also ends.

**Benefit Period Maximum** – The maximum that the Plan will pay for specific Covered Services during a Benefit Period.

**Brand Name Drug** – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

**Copayment** – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or amount charged by the Provider.

**Coinsurance** - A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

**Covered Services** - Services, supplies, or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under the Plan.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance if such Prior Authorization is required in this Benefit Booklet.

A charge for a Covered Service is incurred on the date the service, supply, or treatment was provided to you.

Covered Services do not include services or supplies not documented in the Provider records.

**Covered Transplant Procedure** - Any Medically Necessary human organ and bone marrow / stem cell transplant / transfusion as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloblative therapy.

**Custodial Service or Care** - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas

- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

**Deductible** – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before the Plan will pay for those Covered Services in each Benefit Period.

**Dependent** – A Member of the Subscriber's family who is covered under the Plan, as described in the "Eligibility and Enrollment" section.

**Effective Date** – The date that a Subscriber's coverage begins under the Plan. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work.

A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise indicated in this Benefit Booklet.

**Eligible Person** – A person who meets the Employer's requirements and is entitled to apply to be a Subscriber.

**Emergency** - A medical condition that involves acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson with an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in:

1) Serious jeopardy to your health, or, for a pregnant women, serious jeopardy to the health of the woman or her unborn child;
2) Serious impairment to your bodily functions; or
3) Serious impairment of one or more of your body organs or parts.

It includes traumatic bodily injuries that result from an accident.

**Emergency Care** - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

**Employer** - The legal entity contracting with the Administrator for the administration of group health care benefits.

**Enrollment Date** – The day the Employer or Member signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that employment begins).

**Experimental / Investigative** - Any procedures, treatment, supply, device, equipment, facility, or drug (all services), determined by Our Medical Director or his or her designee **NOT** to:

- Have final approval from the appropriate government regulatory body; or
- Have the scientific evidence which permits conclusions concerning the effect of the technology on health outcomes; or
- Improve the net health outcome; or
- Be as beneficial as any established alternative; or
- Show improvement outside the investigational settings.

In addition to the above criteria, We will consider the degree of acceptance of the product or service in the organized medical community.

A request for an advance determination may be submitted in writing to Our Customer Service Department at the address listed in the front of this handbook. A decision will be made within five (5) working days of receiving the request. If prior written approval for a treatment, service or supply is provided, benefits will be paid if the Member's coverage is in force and if the approval has not expired at the time such treatment, service or supply is provided.

**Family Coverage** – Coverage for the Subscriber and all eligible Dependents.

**Fees** - The periodic charges that are required to be paid by you and/or the Employer to maintain the benefits under the Plan.

**Formulary** - The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

**Generic Drugs** – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency, and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

**Identification Card / ID Card** – A card issued by Us, showing the Member's name, membership number, and occasionally coverage information.

**Inpatient** – A Member who receives care as a registered bed patient in a Hospital or other Provider where a full day's room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours.

**Late Enrollee** – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under the Plan, and who did not qualify for Special Enrollment.

**Lifetime Maximum** – The maximum dollar amount the Plan will pay for Covered Services during your lifetime. While Prescription Drugs do not accumulate toward the Lifetime

Maximum, once the Lifetime Maximum has been reached, no additional benefits for Prescription Drugs will be paid.

**Mail Service** – Our Prescription Management program that offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service, which has entered into a reimbursement agreement with Us, and sent directly to your home.

**Managed Care Fee Schedule** - Reimbursement selected from the Network Provider fee schedules to be applied to Non-Network Providers.

**Maximum Allowable Amount** - The maximum amount that the Plan will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

**Medically Necessary / Medical Necessity** - Procedures, supplies, equipment, or services that We determine to be:

1) Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2) Provided for the diagnosis or direct care and treatment of the medical condition; and
3) Within the standards of good medical practice within the organized medical community; and
4) Not primarily for the convenience of the patient's Physician or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely provided.

The most appropriate procedure, supply, equipment, or service must satisfy the following requirements:

1) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
2) Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
3) For Hospital stays, acute care as an Inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

**Medicare** - The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

**Member** – A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required payment of Fees; Members are sometimes called "you" or "your" in this Benefit Booklet.

**Network Provider** – A Provider who has entered into a contractual agreement or is being used by Us, or another organization, which has an agreement with Us, to provide Covered Services and certain administration functions for the Network associated with the Plan.

**Network Transplant Provider** - A Provider that has been designated as a "center of excellence" by Us and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A provider may be a Network Transplant Provider with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

**New FDA Approved Drug Product or Technology** - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed Drug product but new manufacturer: a product that duplicates another firm's already marketed Drug product (same active ingredient, formulation, or combination);
- Already marketed Drug product, but new use: a new use for a Drug product already marketed by the same or a different firm; or
- Newly introduced generic medication: generic medications contain the same active ingredient as their counterpart brand-named medications.

**Non-Network Provider** - A Provider who has not entered into a contractual agreement with Us for the Network associated with the Plan. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

**Non-Network Transplant Provider** - Any Provider that has **NOT** has been designated as a "center of excellence" by Us or has not been selected to participate as a Network Transplant Provider by a designee.

**Non-Primary Procedure** - A separate surgical procedure performed by a Physician on the same patient during the same operative session or on the same day.

**Open Enrollment** – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; see "Eligibility and Enrollment" section for more information.

**Out of Pocket Limit** - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Benefit Booklet and/or the Schedule of Benefits.

**Outpatient** - A Member who receives services or supplies while not an Inpatient.

**Pharmacy and Therapeutics (P&T) Committee** – A committee of Physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review, and/or approve guidelines related to how and when certain Drugs and/or therapeutic categories will be approved for coverage.

**Plan** - The group health benefit plan provided by the Employer and explained in this Benefit Booklet.

**Prescription Legend Drug, Prescription Drug, or Drug** – A medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1) Any Prescription Legend Drug that is approved by the Food and Drug Administration for the treatment of HIV infection or HIV-related illness, and that is in or has completed a phase three (3) clinical investigation, if the drug is prescribed and administered in accordance with the treatment protocol approved for such drug.
2) Compounded (combination) medications, which contain at least one such medicinal substance.
3) Insulin, diabetic supplies, and syringes.

**Prescription Order** – A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

**Primary Care Physician ("PCP")** – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics / gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

**Prior Authorization** – The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

**Provider** – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan allows. This includes any Provider rendering services that are required by law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID card.

- **Alternative Care Facility** – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan allows, which provides Outpatient Services primarily for but not limited to:

  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
  2. Surgery
  3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:

  1. Is licensed as such, where required;
  2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  4. Does not provide Inpatient accommodations; and
  5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Cardiac Rehabilitation Specialist**

- **Certified Advance Registered Nurse Practitioner** - See information under "Nurse Practitioner" below.

- **Certified Nurse Midwife** - When services are supervised and billed for by an employer M.D.

- **Certified Operating Room Technician** - When services are supervised and billed for by an employer M.D. for surgical assistance only.

- **Certified Registered Nurse Anesthetist** - When services are performed in collaboration with an M.D. and billed by a certified facility or Hospital.

- **Certified Surgical Assistant** - See information under "Surgical Assistant" below.

- **Certified Surgical Technician** - When services are supervised and billed for by an employer M.D. for surgical assistance only.

- **Dialysis Facility** - A facility that mainly provides dialysis treatment, maintenance, or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:

  – Provides skilled nursing and other services on a visiting basis in the Member's home; and
  – Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Home Infusion Facility** - A facility which provides a combination of:

  1. Skilled nursing services
  2. Prescription Drugs
  3. Medical supplies and appliances

  in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care, which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. Provides room and board and nursing care for its patients;
  2. Has a staff with one or more Physicians available at all times;
  3. Provides 24 hour nursing service;
  4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. Nursing care
  2. Rest care
  3. Convalescent care

4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

- **Laboratory (Clinical)**

- **Licensed Marriage & Family Therapist (L.M.F.T.)**

- **Licensed Practical Nurse** - When services are supervised and billed for by an employer M.D.

- **Licensed Professional Counselors**

- **Nurse Practitioner** - An individual licensed as a registered nurse, who:

  1. Is certified as a primary care Nurse Practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or
  2. Holds a master's degree in nursing from an accredited school of nursing; or
  3. Before March 31, 1990, successfully completed a formal one (1) year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care. The program must include at least four (4) months of classroom instruction and a component of supervised clinical practice, and award a degree, diploma or certificate to individuals who successfully complete the program; or
  4. Has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but does not satisfy the requirements set forth in paragraph (3) above, and has performed such an expanded role for a total of twelve (12) months during the eighteen (18) month period ending July 1, 1978.

  Covered Services provided by a Nurse Practitioner must be performed in collaboration with an M.D. and billed by a covered Physician.

- **Occupational Therapist**

- **Pharmacy (Pharmacist)** - An establishment licensed by state law to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist**

- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), doctor of dental medicine (D.D.M.), dental surgeon (D.D.S.), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).

- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse First Assistant** - When services are supervised and billed for by an employer M.D.

- **Registered Nurse** - When services are supervised and billed for by an employer M.D.

- **Regulated Physician's Assistant** - When services are supervised and billed for by an employer M.D.

- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified)**

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. Mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. Provides care supervised by a Physician;
  3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
  4. Is not a place primarily for care of the aged, Custodial or domiciliary care, or treatment of alcohol or drug dependency; and
  5. Is not a rest, educational, or custodial Provider or similar place.

- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.

- **Speech Therapist**

- **Supplier of Durable Medical Equipment, Prosthetic Appliances, and/or Orthotic Devices**

- **Surgical Assistant** - A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

  Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Transitional Care Provider** - *Please refer to the "Behavioral Health & Substance Abuse Services" provision in the "Covered Services" section of this Benefit Booklet for further details.*

- **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

**Provider Directory** A handbook (separate from this Benefit Booklet) that lists the Providers who participate in the Plan's network. These are Providers who have a contract with Us to provide services under the Plan, often at discounted rates. Different Provider Directories exist for different plans. You can find the most current Provider Directory for the Plan by visiting Our website at www.anthem.com.

If you do not have Internet access, you can obtain a copy of the Provider Directory by calling Our customer service department. We will supply this to you, free of charge.

**Recovery** – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

**Service Area** – The geographical area where Covered Services are available, as approved by state regulatory agencies.

**Single Coverage** – Coverage that is limited to the Subscriber only.

**Special Enrollment** – A period of enrollment in which certain Eligible Persons or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc.

**Specialty Care Physician (SCP)** - A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

**Stabilize** - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- Your transfer from an emergency department or other care setting to another facility; or
- Your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

**Subcontractor** – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

**Subscriber** - An employee or member of a group who is eligible to receive benefits under the Plan.

**Therapy Services** – Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

**Totally Disabled (or Total Disability)** A condition resulting from illness or injury in which, as certified by a Physician:

1. You, the Subscriber, are not able to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit; and
2. The Dependent is unable to perform his or her normal activities of daily living.

**We, Us, Our** - *Please refer to the definition of "Administrator" above.*

# ADDITIONAL INFORMATION FROM YOUR EMPLOYER

**Important Note:** The information in this section has been provided at the request of your Employer, Grede Foundries. Please direct all questions regarding this information to Grede.

## Plan Is Not A Contract Of Employment

Nothing contained in this Plan will be construed as a contract or condition of employment between the Employer and any employee. All employees are subject to termination of employment to the same extent as if this Plan had never been adopted.

## Special Situations, Extension of Coverage

### Disability

If you are approved for long-term disability benefits, coverage for you and your Dependents may be continued for up to 29 months, if you pay any required contributions toward the cost of coverage and otherwise qualify for the extension to 29 months (see "Continuation section of this booklet for further information.). For the initial 18-month period, your contributions will be the same as those of active employees. After the initial 18 months, if you and your Dependents qualify to continue coverage for an additional 11 months, your contribution rate will be 150% of the full premium. Your coverage during the disability will be the same coverage offered to active employees and will be under their conditions and restrictions. Coverage continued under this provision runs concurrently with coverage continued under COBRA.

### Retirement

Although subject to change in the future, currently, if you commence an early, normal or late retirement benefit at age 55 or later and with 10 years of service, and had been enrolled in a Grede Foundries, Inc. medical plan just prior to retiring, you and your eligible Dependents may be eligible to elect retiree coverage. Prior to age 65, coverage may be continued under the Low Deductible Option, Medium Deduction Option or High Deductible Option of this Plan. To be eligible, you must enroll for coverage effective with the date of your retirement. At age 65 you may be eligible to purchase coverage under the Medicare Supplement Plan. To purchase retiree coverage you must pay 100% of the premium.

### Death Of Employee

Should you die while employed by Grede Foundries, Inc., and you would have been eligible for retiree medical coverage at the time of your death, your surviving spouse and Dependents will continue to be covered by the Plan, if they pay any required contributions toward the cost of the coverage. Coverage for your Dependents will end the earliest of the date a Dependent no longer

meets the eligibility requirements, the date a Dependent becomes covered under another group health plan, the date your surviving spouse is entitled to Medicare, the date your surviving spouse remarries, or the date this plan terminates. Coverage continued under this provision is in addition to coverage continued under COBRA.

## Your Privacy Rights

As a participant in the Plan, you are entitled to certain rights concerning your protected health information under the Health Insurance Portability and Accountability Act (HIPAA). The following describes how health information about you may be used and disclosed and how you may access this information.

The Plan is permitted to make certain types of uses and disclosures of protected health information under applicable law for treatment, payment and health care operations purposes.

## Use and Disclosure of Information to and from Grede Foundries, Inc.

The Plan may disclose protected health information to Grede Foundries, Inc. (the "*plan sponsor*") under limited circumstances. The Plan will disclose protected health information to the *plan sponsor* only upon receipt of a certification by the *plan sponsor* that the Plan documents have been amended to incorporate and to abide by these privacy provisions.

The Plan may disclose summary health information to the *plan sponsor* for the purposes of obtaining premium bids, insurance coverage, or modifying, amending or terminating the Plan.

The Plan may disclose protected health information to carry out Plan administration functions that are consistent under applicable law. The Plan may not disclose protected health information to the *plan sponsor* for the purpose of employment-related actions or decisions or in connection with other benefits or employee benefit plans of the *plan sponsor*.

A limited number of employees of the *plan sponsor* will have access to protected health information for the purposes of carrying out Plan administration functions in the ordinary course of business. These employees are generally in the Human Resources Department.

These employees will only use protected health information for Plan administration functions, consistent with the Plan's privacy policies and procedures, the Standards for Privacy of Individually Identifiable Health Information, other applicable federal or state privacy law and the department's privacy policies. Should an employee of the *plan sponsor* not comply with the Plan's privacy policies and procedures, the Standards for Privacy of Individually Identifiable Health Information, or other federal or state privacy law, the employee will be subject to corrective action. The *plan sponsor* will promptly implement the contingency plans to mitigate any deleterious effect of improper use or disclosure of protected health information by Grede Foundries, Inc. employees or by the Plan's business associates.

If feasible, the *plan sponsor* must return or destroy all protected health information received from the Plan that the *plan sponsor* maintains in any form. The *plan sponsor* cannot retain copies of such information when it is no longer needed for the purpose for which disclosure was made. If the return or destruction of protected health information is not feasible, the *plan sponsor* will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. The *plan sponsor* has an obligation under the law to retain records for its Plan administrative functions, and will retain the required records, which may or may not contain protected health information as required under the law. The *plan sponsor* must report to the Plan any use or disclosure of protected information that is inconsistent with the uses or disclosures provided for which the *plan sponsor* becomes aware.

The *plan sponsor* must make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the Standards for Privacy of Individually Identifiable Health Information.

## Use and Disclosure of Health Information by the Plan

The Plan will not use or disclose protected health information other than as permitted or required by the Plan documents or as required by law. For instance, the Plan is permitted to disclose minimum necessary protected health information without your authorization for public health activities, health oversight activities, research and judicial and administrative proceedings. The Plan is permitted to disclose protected health information to law enforcement officials as required by law. The Plan is also required to disclose protected health information to you or your personal representative to the extent you have a right of access to the information and to the U.S. Department of Health and Human Services on request for complaint investigation or compliance review.

The Plan's business associates are permitted to use protected health information received from the Plan for the specific activities for which those business associates are contracted. Before receiving your protected health information, the Plan's business associates must agree to the same restrictions and conditions that apply to the Plan and *plan sponsor* under the Standards for Privacy of Individually Identifiable Health Information and other applicable federal or state privacy laws. The Administrator is considered a business associate of the Plan.

## Access, Amendment and Accounting of Health Information

You have a right to request access to inspect and obtain a copy of your protected health information that the Plan and the Plan's business associates maintain in a designated record set. The Plan has established procedures in its privacy policies and procedures to grant access to your protected health information. The Plan has a right to deny your request for access, and you have the right to request a review of that denial under certain circumstances, pursuant to the provisions of 45 CFR § 164.524. The designated record set that the Plan maintains includes documentation

about enrollment, payment, claims adjudication, or case/medical management. To request access to your protected health information contact your Human Resources Department.

You have a right to request the Plan amend your protected health information that the Plan and the Plan's business associates maintain in a designated record set. The Plan has established procedures in its privacy policies and procedures to allow amendment to your protected health information. The Plan has a right to deny your request for amendment, and you have the right to attach a statement of disagreement, pursuant to the provisions of 45 CFR § 164.526. To request an amendment to your protected health information, contact your Human Resources Department.

Pursuant to 45 CFR § 164.528, you have a right to request an accounting of disclosures of your protected health information made by the Plan six years prior to the date on which the accounting is requested, beginning with the effective date of the Standards for Privacy of Individually Identifiable Health Information, which is April 14, 2003.

**Example 1**: You request an accounting on September 14, 2003. The Plan is obligated to account for disclosures made from April 14, 2003 through September 14, 2003.

**Example 2**: You request an accounting on September 14, 2010. The Plan is obligated to account for disclosures made from September 14, 2004 through September 14, 2010.

The Plan does not have to account for disclosures made:

- to you;
- to carry out treatment, payment and health care operations;
- pursuant to your authorization;
- incident to a use or disclosure otherwise permitted under the Standards for Privacy of Individually Identifiable Health Information;
- for national security or intelligence purposes;
- as part of a limited data set;
- occurred prior to April 14, 2003; or
- for other reasons listed in 45 CFR § 164.528.

To request an accounting of disclosures of your protected health information, contact your Human Resources Department.

## Complaints

If you believe your privacy rights have been violated, you may complain in writing to the Plan at Grede Foundries, Inc. P.O. Box 26499, Milwaukee, WI, 53226-0499 or by calling (414) 257-3600. You also may complain to the Secretary of the Department of Health and Human Services at Hubert H. Humphrey Building, 200 Independence Ave. SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

## Your Health Information And Privacy

Your health information is confidential, and your privacy will be protected. Medical information obtained through administrative services, including medical claims and pharmacy claims, may be used to help identify the appropriate level of care support, case management or other programs available to you as described in the Plan. You may receive prescription drug refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your health information also may be used for quality assessment and improvement activities related to your medical benefits. Medical information obtained through these administrative services will not be used to make employment and personnel decisions.

Note: The following terms as used in this section are defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164): "protected health information," "summary health information," "business associates," "personal representative," "designated record set," and "limited data set."

## Security

In compliance with the Security Standards ("Security Rule") under the Health Insurance Portability and Accountability Act of 1996, the *plan sponsor* and the Plan's business associates have safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that it creates, receives, maintains or transmits. A limited number of employees of the *plan sponsor* will have access to protected health information for the purposes of carrying out Plan administration functions in the ordinary course of business, and there are reasonable and appropriate security measures in place to ensure that only these employees will have access to information. The *plan sponsor* will report to the Plan any security incident of which it becomes aware.

# ERISA INFORMATION AND STATEMENT OF ERISA RIGHTS

**NOTE: This section is not a part of your Benefit Booklet. The Administrator is not responsible for any statements contained herein that are not set forth in the Administrative Services Agreement or the Benefit Booklet.**

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. This information is outlined below.

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- **Receive Information About Your Plan and Benefits**

  Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
  Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

- **Continue Group Health Plan Coverage**

  Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

  Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled

to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion after your Enrollment Date as stated in the Benefit Booklet.

- **Prudent Actions by Plan Fiduciaries**

  In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- **Enforce Your Rights**

  If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

  Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with Your Questions**

  If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about

your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# IMPORTANT NOTICE FROM GREDE FOUNDRIES, INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Grede Foundries, Inc.("your Plan") and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.**

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Grede Foundries, Inc. has determined that the prescription drug coverage offered by your Plan is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

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**Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.**

Individuals can enroll in a Medicare prescription drug plan when the first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

**If you do decide to enroll in a Medicare prescription drug plan and drop your Grede Foundries, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.**

**Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.**

You should also know that if you drop or lose your coverage with Grede Foundries, Inc. and

don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

**For more information about this notice or your current prescription drug coverage ...**

You may contact Grede Foundries, Inc. Employee Benefits Department for further information about this notice or your coverage at 414-257-3600. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Grede Foundries, Inc. changes. You also may request a copy.

**For more information about your options under Medicare prescription drug coverage ...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1 -800-MEDICARE (1 -800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare, which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.**

| | |
|---|---|
| Date: | 1/1/2007 |
| Name of Entity/Sender: | Grede Foundries, Inc. |
| Contact--Position/Office: | Employee Benefits Department |
| Address: | P.O. Box 26499<br>Milwaukee, WI 53072 |
| Phone Number: | 414-257-3600 |

# GENERAL EMPLOYER INFORMATION

**Important Note:** The information in this section has also been provided at the request of your Employer, Grede Foundries. Please direct all questions regarding this information to Grede.

Type Of Plan

A welfare plan providing group medical and prescription drug benefits. Dental benefits are described in a separate plan document.

Name And Address Of The *Plan Sponsor*

Grede Foundries, Inc.
P.O. Box 26499
Milwaukee, WI 53226-0499
414-257-3600

Name And Address Of The *Plan Administrator*

Grede Foundries, Inc.
P.O. Box 26499
Milwaukee, WI 53226-0499
414-257-3600

Name And Address Of The Designated Agent For Service Of Legal Process

Group Health Plan Committee
Grede Foundries, Inc.
P.O. Box 26499
Milwaukee, WI 53226-0499
414-257-3600

Name And Address Of The Third Party *Contract Administrator*

Anthem Blue Cross and Blue Shield
N17 W24340 Riverwood Drive
Waukesha, WI 53188

Internal Revenue Service And Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 39-0628000. The Plan number is 503. The Plan name is the Grede Foundries Group Health Plan.

*Plan Year*

The *plan year* is the 12-month period beginning January 1 and ending December 31.

Method Of Funding Benefits

Health benefits are self-funded from accumulated assets and are provided directly from the *plan sponsor.* The *plan sponsor* may purchase excess risk insurance coverage which is

intended to reimburse the *plan sponsor* for certain losses incurred and paid under the plan by the *plan sponsor*. Such excess risk coverage, if any, is not part of the Plan.

Payments out of the Plan to *health care providers* on behalf of the covered person will be based on the provisions of the Plan.